

Exploring the discourse of mental illness and employment

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Dedication

This thesis is dedicated Nic.

Nic, you are wonderful human, I love you lots, and you deserve a much easier time of everything. I hope my research can contribute to that change.

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Abstract

Within this research I examined the discourse of mental illness and the discourse of work impacting the experience of individuals with mental illness in New Zealand, particularly in the workplace. Discourse was analysed to provide an understanding of the current social strategies and social responses to mental illness, with a focus on specifically how mental illness is responded to within the workplace. Foucauldian discourse analysis, specifically a Foucauldian archaeological and genealogical approach, was used to examine the statements and discursive formations present within participant interviews and the documents analysed. Using Foucauldian discourse analysis, I mapped discourse embedded within mental health services, supported employment services, and workplaces. Alongside this, I examined how discourse constructs subject identities, particularly focusing on how participants with experience of mental illness constructed their subject identities, and how this impacts their engagement and participation in the workplace. Nine participants with diverse subject identities and roles were interviewed for this research, including a total of five participants with experience of mental illness, two of whom also worked in mental health services, and a further two participants working in supported employment services, and two participants working in management and human resources. Documents were also analysed, particularly media items and social service websites, to gain a broad perspective on the discourse embedded within New Zealand social services, particularly mental health services and supported employment services.

Through analysis of data, I identified that mental illness is often constructed as an individualised experience, which has meant that service strategies and responses to mental illness also tend to offer individualised support and care. Constructing mental illness as an individualised experience has meant that collective, systemic responses to mental illness are absent, or not well developed. This is particularly critical in work settings where there is still a lack of appropriate attention to the rights of individuals with mental illness and their needs are still not adequately recognised, discussed, and accommodated. The development of a collective identity and collective understanding of mental illness, similar to that reflected in disability discourse, may better enable people with mental illness to challenge systemic discrimination.

CHAPTER ONE: INTRODUCTION

1.1: Introduction

This research topic emerged in part out of my reflections on a personally difficult time, when a dear friend of mine was struggling with his mental illness, not managing life well, and feeling unable to contribute to or fully exist in the world due to his economic circumstance. I observed that for my friend, not working, feeling unable to meaningfully participate, and having no economic security contributed to his sense of despair, stress, and disengagement with the world. These personal observations led me to this research project and questions about how the experience of mental illness is affected by the economic realities and systems in society. My observations of my friend's struggle in engaging with mental health services when he was suicidal, and also his battle to get financial support when he was unemployed, made me realise how hard it is for individuals with mental illness to survive in a world with unaccommodating social services and systems.

When I began this research project, I was unsure where it would lead me; I only knew that I needed to have a better understanding of this area. I wanted to examine the social systems of both economics and mental health, and see how they impacted the experiences of individuals with mental illness. Initially, I imagined that work and economic structures would be at the centre of this research project, but my focus and understanding shifted to how society, including workplaces, construct the experience of mental illness, and what this means in terms of engagement with employment, and also what this means for individuals with mental illness themselves. The social construction of mental illness impacts the way that society responds to mental illness, both within the workplace and within mental health care; it also has a significant impact on the identity of individuals with mental illness and how they engage with the world.

Mental illness is an area of growing concern and focus, notably in media discussion but also in the increasing prevalence of mental illness globally (OECD, 2012). The experience of mental illness needs to be examined within the wider social context; this research examines the experience of mental illness within the economic context of New Zealand society. My friend's experience and on-going struggle with his mental illness is intertwined with his economic circumstance and reality. Economic circumstances are particularly important to note as work is seen by society as one's pinnacle achievement and the means to participation in adult life, and without economic security life is difficult if not impossible. Sadly,

individuals with mental illness often experience difficulty finding work and maintaining employment, as the economic system is not very accommodating of difference (Dollard & Winefield, 2002; Ford et al., 2010).

1.2: Discourse of Mental Illness, Work, and Disability

Mental illness has become an increasingly prevalent experience, in New Zealand and globally, and is now the leading cause of disability worldwide (Elraz, 2018). Alongside a growing concern over increasing rates of mental illness, governments and global bodies have highlighted their concern regarding the economic burden of mental illness, noting the financial costs associated with mental health treatments, and the unemployment, part-time employment, sick leave, and loss of productivity associated with the experience of mental illness (Harder, Wagner, & Rash, 2016; OECD, 2012). The experience of mental illness and economic outcomes are linked, not only in terms of the broad economic burden of mental illness, but also in terms of unemployment or poor employment which may result in mental illness (Bartley, 2006; Broom et al., 2006), and people with mental illness struggling to find and maintain employment (Dollard & Winefield, 2002; Rebeiro Gruhl, Kauppi, Montgomery, & James, 2012).

The experience of mental illness can impact an individual's economic reality and experience in the workplace, and the discourse of work and the discourse of mental illness continues to construct particular, often discriminatory, social realities for individuals with mental illness (Elraz, 2018; Krupa, Kirsh, Cockburn, & Gewurtz, 2009). Employment is frequently discussed and viewed as a means of achieving good outcomes for individuals with a mental illness (Harder et al., 2016; O'Brien, 2013). However, despite the push by governments for encouraging individuals with mental illness into employment, employment outcomes for individuals with mental illness remain poor (Boardman, Grove, Perkins, & Shepherd, 2003; Harder et al., 2016). The ability for individuals diagnosed with a mental illness to find employment, retain their employment, and be in a well-paid role are often negatively impacted by their illness and the social stigma and perceptions attached to it (Ford et al., 2010). Research and literature examining the overlapping experience of mental illness and economic structures tend to focus on discrimination, stigma, unemployment or insecure employment, supported employment, and welfare provision. This research aims to contribute to an understanding of the experience of mental illness as it relates to economic circumstance

and work, but additionally broadly examines the experience of mental illness, how it is constructed, and how this impacts social responses to mental illness.

In New Zealand currently, there is a wide public discussion and media focus on the mental health crisis. The growing prevalence of mental illness and suicide in New Zealand has resulted in a national government inquiry into mental health and addiction. The *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* is the first national inquiry conducted in New Zealand in 22 years (The Government Inquiry into Mental Health and Addiction, 2018). In New Zealand there has been particular concern regarding the growing needs of individuals with mental illness and addiction, with one in five New Zealanders living with either a mental illness or an addiction each year, the mental health system has struggled to accommodate the needs of the population (Health and Disability Commissioner, 2018a). Mental health services were previously designed to serve 3% of the New Zealand population, but with close to 20% of the New Zealand population experiencing mental illness or mental distress annually, mental health services in New Zealand are currently neither accessible to nor able to support a large proportion of the population of people who need such services (The Government Inquiry into Mental Health and Addiction, 2018).

The underfunding of mental health services also contributes to problems experienced in relation to the lack of accessibility to mental health and addiction services in the present mental health system. Access to mental health and addiction services, both inpatient and outpatient services, has increased by 73% in New Zealand in the last 10 years, while funding over the same period of time has only increased by 40%, putting a lot of pressure on services (Health and Disability Commissioner, 2018a). Alongside underfunding of services, there is also a lack of diverse service provision available to individuals with mental illness; medication for mental illness is well funded and supported but other therapeutic options remain inaccessible (The Government Inquiry into Mental Health and Addiction, 2018). There is a nationwide consensus, according to the recent *He Ara Oranga* report, that the New Zealand Mental Health System needs to be significantly and structurally changed in order to meet the needs of New Zealanders experiencing mental illness (The Government Inquiry into Mental Health and Addiction, 2018). The mental health structures and services in New Zealand, and globally, have undergone significant changes in the past, for example the process of deinstitutionalisation, which shifted service provision from large mental institutions to community-based care (Braslow, 2013; Dew, Scott, & Kirkman, 2016; Moon,

2000). Again, it appears that change is necessary and perhaps on the horizon for mental health services in New Zealand.

The discourse embedded within social services and systems, particularly mental health and economic systems in New Zealand, influences the experience of individuals with mental illness. Disability discourse, while often discussed separately to mental illness discourse, is important to examine in relation to social services and systems as well, particularly in relation to work contexts and experiences of the rights of individuals with mental illness in the workplace. While disability and mental illness are often discussed separately, both in the media and within literature and research, mental illness is suggested to be the highest cause of disability worldwide (Elraz, 2018), with the Organisation for Economic Cooperation and Development's (OECD) recent research suggesting that between a third and half of all long-term sickness and disability claims worldwide were due to mental illness (OECD, 2015). Disability and mental illness are also frequently conflated administratively and legally, for example within the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD) and the Health and Disability Commission in New Zealand (Bartlett, 2012; Beresford, 2000; Health and Disability Commissioner, 2018b).

Disability discourse has evolved and challenged the earlier medical discourse which defined disability focusing on impairments (Oliver, 1996). Instead disability discourse, specifically influenced by the social model of disability, has focussed on how social, environmental, and political structures disable individuals (Oliver, 1996). As highlighted by Barnes and Mercer (2005), in the 1960s people with disabilities established groups to protest the structural barriers and lack of access individuals with disabilities encountered within employment, education, housing, transport, social relationships, and leisure activities. Medical discourse previously constructed the experience of disability as one that was limited by impairments or biological limitations, whereas disability discourse constructed disability as caused by disabling, unaccommodating, and oppressive social, political, and environmental structures (Barnes & Mercer, 2005; Soldatic & Chapman, 2010). However, Oliver (2013) recently noted that the disability discourse which once united the collective experience of disability is being challenged again by a focus on impairments and medical differences. Individuals with mental illness have similarly attempted to challenge medical constructions of mental illness, however, there remains a strong medical or health-based discourse underpinning mental health systems, social practices, and treatments offered (Rudnick, 2014).

Disability discourse could provide an alternative means to understanding the collective and social experience of mental illness, including the rights of individuals with mental illness, particularly in the workplace (Beresford, 2000; Wand & Wand, 2013). My research examined the discourse of mental illness that constructs and constrains the reality of individuals with mental illness in New Zealand; it also examined how economic discourse impacts the experience of individuals with mental illness, particularly in relation to their experience of employment, unemployment, and welfare provision. The experiences and economic realities of individuals with mental illness are frequently impacted by discrimination discourse, which is why disability discourse is also examined as part of exploring experiences of accommodation in the workplace.

Foucauldian discourse analysis begins by problematising an aspect of present experience: in the case of this research, the experience of mental illness and the economic realities of individuals with mental illness in New Zealand. Foucauldian discourse analysis offers the opportunity to critique discourse embedded within social systems and social practices, and to explore who and to what ends particular discourse is serving, and how it can either limit or facilitate ways of thinking and ways of being in the world (Hook, 2001). I used Foucauldian discourse analysis to examine discourse impacting the experience of individuals with mental illness, not only with regards to their experiences at work and their economic realities but also to consider how discourse can shape and constrain an individual's identity. Subject identity and the management of identities, were discussed by Foucault as both the product of knowledge and power, and a function of discourse (Garrity, 2010). In my research I examined both discourse embedded within systems and social practices, and how individuals interpret, reject, accept, or adapt discourse to construct their own identities and subject positions in society.

1.3: Motivation for Study

This research project emerged out of personal observations within both the mental health system and economic systems, and my own academic interests as a researcher. Witnessing my friend's experience changed my understandings of the structural inequities and social realities of individuals with mental illness. I had anticipated more caring responses from the people and processes in the mental health system and unemployment support systems. My observations highlighted how the reality of living with a mental illness can be extremely

difficult, not only because the symptoms of mental illness can be challenging, but because the systems designed to assist individuals with mental illness appeared to be over-burdened and were difficult to access and navigate. The systems surrounding mental illness appeared to only engage at the point of severe need, and proving that the need was severe was part of the battle. Similarly, the economic structures would not engage to support my friend without sufficient proof; welfare response relied on need, and required significant proof to suggest that my friend was deserving of financial support. One phone call to emergency services illustrated this. I had called out of concern that my friend was suicidal and likely to hurt themselves, and the response was: “How suicidal are they?”, “Is it likely they will hurt themselves today?” I said I could not be certain, and they then apologised saying, if the threat was not imminent, there was nothing they could do. At this point, I was alarmed, distressed, and uncertain about how to proceed. Navigating such structures, which appear to be designed to weed out having to provide care for people unnecessarily, when an individual is struggling to find motivation to do the basics such as shower and eat, is nearly impossible. Considering that individuals who experience mental illness are likely to experience additional aggravating social factors including family violence, trauma, poverty, cultural alienation, social isolation, and broad social deprivation, it is hard to imagine anyone being able to navigate these social systems to receive care and support when they need it (Ewart et al., 2017; Shaw, 2006; The Government Inquiry into Mental Health and Addiction, 2018).

As a researcher, I have a strong interest in social systems and structures of power, and how these impact, control, and influence the lives and experiences of individuals and groups of people. From a young age I was made aware of this, how power can impact individual lives. I grew up in Zimbabwe when the government enacted policies that resulted in my family having to leave the country quickly. This personal experience influenced my academic interest in the social systems and state structures that are often taken for granted. Powerful institutions produce discourse through policy, legislation, and media that can, sometimes violently, impact the lives of individuals and groups of people. While my personal experience reflects a more obvious use of power and discourse by the government to influence the social reality within Zimbabwe, all governments and powerful people, whether politicians or experts in their chosen field, are both subject to discourse and are also in positions to further produce, inhibit, reinforce, adapt, resist, and challenge discourse within society (Garrity, 2010; Hook, 2001).

Dominant discourse embedded within social structures often reflects social norms and is portrayed as ‘the truth’ or the most reasonable and most logical way of doing things. I found that Foucauldian discourse analysis offered a methodology to critique and question the assumptions and perceived ‘truths’ shaping our social reality (Garland, 2014; Hook, 2001). In the case of my close friend, the mental health structures and economic structures are embedded with discourses that privilege specific outcomes and understandings, and influence social practices which limit or encourage particular behaviours and ways of thinking (Hook, 2001). In New Zealand, there have been particular discursive frames which have shaped the services and social practices engaged with mental illness, although these appear to be changing. Different, often contrary, discursive constructions are embedded within social structures, providing various understandings of mental illness, work, economic success, and disability and accommodations. Dominant discursive constructions tend to have greater influence but alternative perspectives can provide significant resistance to dominant understandings. My personal observations and academic interests have merged within this research project and Foucauldian discourse analysis became the clear methodological choice in order to better understand and explore discourse shaping the often oppressive, problematic reality experienced by individuals with mental illness.

1.4: Foucauldian Discourse Analysis

Discourse analysis is a methodology applied in a broad range of disciplines, often with quite different understandings of the concept of discourse (Garrity, 2010; Starks & Trinidad, 2007). To briefly introduce the methodology of discourse analysis it is helpful to examine some of the different understandings of discourse, including a Foucauldian perspective. Discourse analysis originated within linguistic studies, focusing particularly on language, how language was used to achieve particular purposes (Starks & Trinidad, 2007). Critical discourse analysis builds on linguistic discourse analysis and is also influenced by Foucauldian concepts; it explores another variation of discourse, examining language but also the interaction between the researcher, the context in time and place, the subjects speaking or writing of their experience, and the power dynamic within the interaction (Wodak, 1999). Critical discourse analysis can be seen as an extension of the linguistic approach to discourse analysis with an added awareness of power, influenced in part by Foucault’s concept of power within

discourse analysis. Different disciplines and different research projects utilise these differing concepts of discourse and discourse analysis.

By contrast to critical discourse analysis, Foucauldian discourse analysis does not merely draw on limited aspects of Foucault's work. However, within Foucault's understanding of discourse analysis, the concept of discourse and methodology associated with it remained unclear. Foucault did not have a precise methodology; his work evolved over time as did the concepts he used (Garland, 2014; Garrity, 2010; Nicholls, 2009). As a researcher, it is necessary to state explicitly which aspects of Foucauldian discourse analysis will be drawn on. Within this research project, I have drawn on both an archaeological and a genealogical approach to Foucauldian discourse analysis. Discourse, according to Foucault's archaeological perspective, results in the existence of a particular reality (or statement) over another (Foucault, 1969). Discursive formations construct and determine social norms, social practices, and what can or cannot be said (Springer & Clinton, 2015). In this way, language still represents part of Foucault's discourse analysis but it is not limited to language, rather it can include social practices (Foucault, 1969; Garrity, 2010). Foucault, within *The Archaeology of Knowledge*, observed that the form or interaction of each statement is significant in the analysis of discourse, as certain statements require professional power, or knowledge, or other credentials to be said and to be heard (Foucault, 1969; Garrity, 2010). According to Foucault, particularly within a genealogical understanding of discourse analysis, power is inherent within discourse; power produces discursive 'truths' or knowledge, and discourse or knowledge produces or limits power (Garrity, 2010; Hook, 2001). Discourse, according to Foucault, also produces subject positions or subject identities (Foucault, 1969; Garrity, 2010; Nicholls, 2009). Often, an individual or a group may have numerous discursive formations surrounding them, contributing to different subject identities and subject positions, which individuals may also choose to resist or adapt in order to see themselves more positively (Jammaers, Zanoni, & Hardonk, 2016; Nicholls, 2009).

Foucauldian discourse analysis, while an unclear methodology, offers a means to map and critique a particular social phenomenon or a particular social problem (Garland, 2014; Hook, 2001). In the case of this research, I employed Foucauldian discourse analysis to critique the mental health structures, social practices, mental illness discourse, as well as the economic structures, social practices, and work discourse. Also, I examined how discourse can produce particular subject identities and positions, and how participants managed their identity with the associated stigma attached to mental illness. As Foucault did not have a clear

methodological approach, I discuss my research process, and which aspects of Foucauldian discourse analysis in particular I drew on, in detail in my methodology chapter.

1.5: Language Choices Within This Research

Language is an important aspect of discourse analysis. While Foucault stated clearly that language is not to be seen as the primary analysis of discourse, language can still illustrate the dominance of particular ideas which therefore shape social practices (Hook, 2001). A particular challenge in this research was choosing appropriate language to discuss the topic.

1.5.1: Mental Illness and Alternative Terminology

The words available to discuss mental illness are varied and often problematic in how they reference particular understandings and knowledge surrounding mental illness. ‘Mental illness’ as a concept perpetuates an association with medicine and maintains the link between psychiatry and different states of mind; ‘illness’ also highlights abnormality (Gomory, Cohen, & Kirk, 2013). Despite this association, I chose to use the term ‘mental illness’ in my research as I have found some of the alternative language equally problematic and challenging.

Finding the language to discuss mental illness is made more difficult in part due to the broadness of the term. Researchers and writers focussing on this topic area generally prefer to use the language of ‘mental health’ or ‘mental distress’ when discussing mental illness, although these terms are frequently not explained in-depth. Mental illness as a concept contains the experience of individuals with schizophrenia, bi-polar disorder, post-traumatic stress disorder, obsessive compulsive disorder, depression, anxiety, and many more diagnoses and labels. The literature often makes distinctions between ‘common’ mental illnesses or disorders (Ford et al., 2010; Irvine, 2011) and ‘severe’ mental illnesses or disorders (Booth, Francis, McIvor, Hinson, & Barton, 2014; Firmin, Luther, Lysaker, & Salyers, 2015), creating a spectrum of experience. Research and literature does not often explain what constitutes ‘severe’ mental illness; ‘common’ mental illness is more likely to be explained. Irvine (2011) discussed ‘common’ mental illness as stress, anxiety, and depression, Ford et al. (2010) also described ‘common’ mental illness as anxiety and depression. ‘Severe’ mental illness could perhaps be assumed to be any diagnosis other than anxiety and depression,

although this is problematic too as the spectrum of experience of depression and anxiety varies. As Ohlsson (2018) noted within his research, the conceptual ambiguity of mental illness makes clarity difficult to ascertain. The interchangeability of terms related to mental illness present in the media and other sources, such as mental ill-health, mental unwellness, mental disorders, and mental well-being, often creates further ambiguity and confusion (Ohlsson, 2018).

Ideally, individuals with mental illness would shape their own language and words to describe their experience and reality, as Fletcher (2018) highlighted in her research on 'Uncivilising: mental illness', which included finding new narratives and metaphors, and in this way subverting the monoculture of psychiatry and its standard understanding of the mind (Fletcher, 2018). Continuing to frame my research as discussing 'mental illness' is maintaining the monoculture of psychiatry but I resisted the alternative terms such as 'mental health' and 'mental distress'. I resisted the term 'mental health' as this still places mental illness within a health discourse and therefore medical discourse and it is quite an unclear concept. With respect to 'distress', I felt this term did not do justice to the realities of navigating society with a mental illness. Distress seemed to reflect a softening and sanitising of mental illness, primarily for the benefit of the wider public rather than individuals with mental illness themselves.

One choice of language I strongly considered was 'psychiatric disability', in place of the term 'mental illness,' as I would prefer to make a clearer link between the concept of mental illness and the social understandings and discourse of disability. However, individuals with mental illness often do not associate their own experience with having a disability (Beresford, 2000; Mulvany, 2000). There is a complexity in the relationship between mental illness and disability, despite the commonalities in historical treatment and legal frameworks such as the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD) (Beresford, 2000; Corker & Shakespeare, 2002). There is also resistance from both disability theorists and mental illness theorists to the idea that these experiences be discussed together, and the literature framing mental illness within the social model of disability is limited (Beresford, 2000; Corker & Shakespeare, 2002; Mulvany, 2000). Alongside this, the term 'psychiatric disability' also clearly continues to maintain the link to psychiatry, and therefore is still problematic in framing the experience of mental illness. Additionally, as a researcher, 'psychiatric disability' is terminology that I would have felt uncomfortable using with my participants as it has a quality of professionalised jargon.

As there is no ideal term to discuss mental illness, I chose to use the term that is familiar and reasonably clear in that it reflects both the historical experience of individuals with mental illness and the dominance of a health-based, and medical understanding of mental illness. When discussing mental illness, I am referring to more ‘severe’ experiences of mental illnesses rather than ‘common’ experiences of mental unwellness. A ‘severe’ mental illness I would describe as a mental illness that makes functioning within the expectations of society difficult, if not, at times, impossible. I would suggest that severe mental illness is frequently a long-term experience: an illness that can impact an individual for several years of their life, if not their entire life.

1.5.2: Gender Pronouns

An additional consideration I had with regards to language in this research was in relation to gender. For my research, I have chosen to not examine gender due to time constraints and other considerations which will be discussed further in Chapter Four, my methodology chapter. All participants, rather than having a gender-based pronoun of ‘he’ or ‘she’, are instead discussed with the gender-neutral pronoun of ‘their’. I chose to use a gender-neutral pronoun as I have not examined gender in my analysis, and I did not want to add this dimension to my findings’ chapters. Instead participants are only identified by their subject identity, of either: participant with experience of mental illness, participant working in mental health, participant working in supported employment, or participant working in employment settings.

1.6: Thesis Overview

This thesis examined the experience of individuals with mental illness within their economic realities through an analysis of mental illness discourse, economic discourse, and work discourse, as well as disability discourse, rights discourse and disclosure discourse. The construction of subject identities is also examined, looking particularly at how individuals manage their identities and either resist, adapt, or accept discursive formations regarding their subject identity. Foucauldian discourse analysis is used to critique discourse embedded within both mental health and economic systems, as well as the social practices, which are

indicative of the strategies of discourse, reflecting social norms and legitimised practices (Nicholls, 2009).

Chapter Two begins by exploring the context of the research study, highlighting discourses both presently and historically embedded within New Zealand's social services and systems, particularly examining the mental health system and the economic system. Broad discursive constructions present in New Zealand are discussed in this chapter. Firstly, I consider the discourse of mental illness, particularly the discourse of the crisis of mental illness, the medical and contextual discourse of mental illness, recovery discourse, and well-being discourse. Relevant economic discourse and employment discourse are also examined, specifically the welfare to workfare, discrimination and stigma, and disability discourse. Finally rights-based discourse is discussed, making some connection to disability discourse and workplace accommodations.

Chapter Three follows on from this, with a review of literature, further adding to the context of this research while also highlighting the specific gaps in research and literature that this study sought to fill. The chapter is divided into particular themes drawn from a broad reading of literature and research from New Zealand and elsewhere. The chapter begins by examining research and literature on normative discourse and non-normative discourse and subject identities, highlighting how different subject identities can impact work and other spheres of social life. Next, research and literature examining the discourse of mental illness is highlighted, specifically the medical, technical and health-based discourse of mental illness, the contextual and social discourse of mental illness, disability discourse, and finally recovery discourse. Following this, economic discourse in the literature and research is examined starting with neoliberal discourse, discourse of work, the stigma and discrimination of mental illness at work, disclosure of mental illness, unemployment discourse, the workfare state, and the discourse of individual responsibility and employability. This chapter concludes with a discussion on where my research fits within the existing literature and research, and how it furthers the area of study and fills a gap, particularly within New Zealand based research.

Chapter Four expands on my methodology, explaining in more depth Foucauldian discourse analysis and what aspects of Foucault's theories I have drawn on. Initially, Foucauldian discourse analysis is discussed broadly, highlighting some of the critiques of this methodology. Then, more specific concepts of Foucauldian discourse analysis are discussed, specifically archaeology and genealogy. Following this, Foucauldian discourse analysis is

discussed in practice, and looking specifically at how I applied this methodology to my own analysis. Finally the research process and methods are discussed, highlighting key aspects of my research journey, including practical aspects and choices I made regarding my research process and my research analysis.

Chapter Five and Six are the two findings chapters of this thesis. Broadly, Chapter Five highlights the findings related to mental illness discourse and Chapter Six highlights the findings related to the discourse of work. Chapter Five examines dominant discursive constructions of mental illness emphasised within participant interviews and the documents analysed. The analysis of the data followed some of the themes noted within the literature review but also captured specific contextual differences, for example the evolving discourse of recovery in New Zealand, that were apparent within the findings. In Chapter Six, findings regarding economic discourse and work discourse are discussed, alongside participants' experience of disclosure, how the subject identity of mental illness is managed in the workplace, as well as the discourse of disability, the experience of rights and discrimination in the workplace, and workplace accommodations.

In Chapter Seven, I discuss my findings in relation to the literature reviewed and the context of this study, focussing on key findings related to the individualistic discourse embedded within both mental health and economic systems. The individualisation of the experience of mental illness has meant that the responses to mental illness remain individual, rather than looking at or addressing collective experiences of mental illness, for example the experience of discrimination. The impact of discourse on individuals' subject identities is also discussed, exploring how participants and the documents analysed constructed the subject identity of mental illness, and how this subject identity was managed. Within this chapter, there is also an exploration of the lack of a collective discourse surrounding mental illness, with disability discourse discussed as offering an alternative understanding and potential responses to the experience of mental illness. I argue that how mental illness is constructed, whether as an individual or collective experience, has a huge impact on how it is responded to by social systems, including mental health systems and economic systems. If mental illness was constructed as a more collective experience, perhaps workplaces and state services would engage with systemic strategies to better accommodate mental illness and in doing so reduce discrimination.

Finally, in Chapter Eight I conclude by briefly revisiting some of the key findings and implications of this research, specifically looking at implications for individuals with mental illness, implications for workplaces, and implications for services. Alongside this, I also discuss areas that need further research in relation to this research topic in order to better understand the experiences of individuals with mental illness in the workplace.

1.7: Conclusion

This research project examined the discourse of mental illness and discourse of work, and how they impact the experience of individuals with mental illness. My friend inspired this work and was a source of motivation throughout this project. From my observations, the reality of navigating mental health systems, welfare and employment support systems, and work environments with a mental illness appeared unnecessarily difficult, if not at times impossible. I explored discursive constructions embedded within these systems and their impacts, including how mental illness is constructed and responded to by employers and social services within the context of New Zealand. In New Zealand currently there is an emphasis and focus on mental illness by the government and noticable in the media. The next chapter examines this in detail in order to contextualise this research project and provide a broad overview of various discourses present in mental illness and employment in New Zealand.

CHAPTER TWO: BACKGROUND

2.1: Introduction

This chapter examines some of the historical and current discourses impacting the mental health system and economic structures of New Zealand, specifically looking at mental illness discourse and employment discourse. Aspects of New Zealand media, policy documents, and public campaigns are discussed in order to reveal the discussion and implementation of contemporary strategies, which reflect current dominant discourses and also historical discourses influencing the experience of individuals with mental illness. Foucault's genealogical approach to discourse analysis, which is examined in more detail in Chapter Four, highlights the importance of examining history as a way of seeing how social realities and 'truths' have been constructed over time, and how the adopted 'truths' of the present may similarly be deconstructed and critiqued (Tamboukou, 1999). Within New Zealand there are historical influences that impact the discursive formations of mental illness and of work; many of these can be seen throughout the European and western world, however, some aspects are unique to a New Zealand context. It is much easier to see historical discourses shaping society as it can be critiqued at a distance; it is more difficult to look at and name contemporary discourses, although this will also be attempted through examining contemporary social practices. Social practices are the strategies shaped by discourse, often revealing social norms and what is deemed legitimate behaviour and legitimate knowledge (Nicholls, 2009).

2.2: Mental Illness Discourse in New Zealand

The various discourses surrounding mental illness in New Zealand are complex and at times contradictory. However, some key discursive frames are part of public discussion around mental illness currently and can be seen reflected in the services provided for individuals with mental illness, in public campaigns such as 'Like Minds Like Mine', in recent media discussions for example surrounding suicide (McAllen, 2017) and the mental health crisis (Rankin, 2018), and also in recent documents released by the government, specifically the *He Ara Oranga* report (The Government Inquiry into Mental Health and Addiction, 2018). Several dominant discourses are discussed in this chapter, particularly the discourse surrounding stigma and mental health, the discourse surrounding the crisis of mental illness,

medical discourse and social discourse of mental illness, and recovery discourse. Examining these discourses contextualises this research, providing a broad understanding of where this research sits within the current situation for individuals with mental illness in New Zealand. This also provides a baseline understanding of New Zealand's mental health services and experiences from which the findings regarding mental illness discourse discussed in Chapter Five can be understood.

2.2.1: De-Stigmatising Mental Illness: A Focus on Mental Health

A key aspect of mental illness discourse and discussion in New Zealand has been an emphasis on awareness-raising and anti-discrimination campaigns, particularly through the 'Like Minds Like Mine' campaign which has been running since 1997 (Like Minds Like Mine, 2016a), and the 'Mental Health Awareness Week' which has been running since 1993 (Mental Health Foundation New Zealand, 2018a). The aim of these public campaigns has been to ensure that individuals are able to discuss mental illness openly without discrimination; this is seen as a key step both in terms of recovery for individuals, as well as a way to ensure that individuals ask for help rather than hide their experience of mental illness (Like Minds Like Mine, 2016a; Mental Health Foundation New Zealand, 2018a). These campaigns seek to destigmatise mental illness by highlighting it as a normal aspect of life, through sharing real-life stories of individuals with mental illness, and using online platforms and physical advertising to share positive and educational facts about mental illness (Like Minds Like Mine, 2016a). These campaigns highlight the prevalence and commonality of the experience of mental illness, noting that 47% of New Zealanders will experience mental illness in their lifetime (Like Minds Like Mine, 2016a).

The discursive project of destigmatising mental illness and highlighting the importance of mental health has led to a prominent discourse surrounding mental illness, one that tends to focus on action steps and self-management in order to achieve better mental health. For example, the Mental Health Awareness Week highlights the 'Five Ways to Well-being' which include the concepts of: Connect, Take Notice, Keep Learning, Be Active, Give, all of which are arguably beneficial to mental health but offer a very specific self-help discourse for individuals with mental illness (Mental Health Foundation New Zealand, 2018a). While mental health issues or mental illness is discussed as a common experience (one in five individuals in New Zealand live with a mental illness or addiction each year) that the public

should embrace and be empathetic towards (Health and Disability Commissioner, 2018a), many of the public campaigns and awareness-raising campaigns appear to be directed towards or highlight the more moderate or mild experiences of mental illness. The focus on mild or moderate experience of mental illness has led to a critique of awareness-raising campaigns and discussions surrounding mental health, with some commentators in the media suggestioning that mental illness is being sanitised and made more palatable to the public, (McAllen, 2017; Parkinson, 2018; Writes, 2018) which on the one hand does reduce stigma towards mental illness but also highlights only a narrow narrative of the experience of mental illness. Writes (2018, para. 22) noted that Mental Health Awareness Week is not for people like her, “the lost causes”, but it is rather for some other sort of person who can just watch a sunset for their mental health rather than needs affordable professional support, or state interventions, or alternative options beyond medication.

2.2.2: Mental Health Crisis

In recent years, there has been growing focus and attention placed on the ‘crisis’ of mental illness world wide and within New Zealand. A recent Lancet Commission report exploring global mental health, discussed the growing global crisis of mental health and the collective failure to respond appropriately despite increasing knowledge and awareness regarding mental illness (Patel et al., 2018). In New Zealand, there have been similar discourse and discussions surrounding the ‘mental health crisis’; the crisis discussed in a New Zealand context relates to underfunding, under-resourcing, and overburdenment of mental health services (Elliot, 2017; Health and Disability Commissioner, 2018a). In a recent report on a study conducted by ActionStation (Elliot, 2017), which gathered over 500 stories of individuals’ experiences of the mental health system in New Zealand, the most common feedback put forward by participants related to lack of access to mental health services when they were needed, and the long wait times for receiving services. The second most common responses by participants in that study related to the strain on mental health workers and other professionals who were under-resourced and overstretched in their workplaces (Elliot, 2017). In New Zealand, the mental health services are designed to provide care for 3% of the population, catering for the more severe experiences of mental illness (Health and Disability Commissioner, 2018a). However, even those with severe experiences of mental illness struggle to access appropriate care and support, and people with moderate and mild

experiences of mental illness struggle to access any support (Health and Disability Commissioner, 2018a; The Government Inquiry into Mental Health and Addiction, 2018).

Globally, there is also an emphasis on the crisis related to the economic burden of mental illness. This crisis is considered, for example in OEDC reports (OECD, 2012, 2015), to be associated with the growing prevalence of mental illness impacting and overwhelming health care systems, as well as the impact of mental illness on the labour market through unemployment, absenteeism, presenteeism, and a general loss of productivity. The economic burden of mental illness was also noted within the *He Ara Oranga*, the recent mental health and addictions report commissioned by the New Zealand Government, stating that in New Zealand, the cost of mental illness and addiction equates to approximately 12 billion New Zealand dollars annually (The Government Inquiry into Mental Health and Addiction, 2018). Funding for mental health services in New Zealand has increased by 40% over the last 10 years, whereas access to mental health services has increased by 73% over the same period of time, putting pressure on services (Health and Disability Commissioner, 2018a). The economic and political rationales behind these funding allocations or lack of funding allocations have contributed to the growing discourse and experience of ‘crisis’ in relation to mental health and mental illness in New Zealand. The ‘crisis’ of mental illness can be seen as part of a state and global lack of collective response, as observed in the *Lancet Commission’s Report* (Patel et al., 2018). This lack of collective response is in part due to the discourse of mental illness that constructs mental illness as an individual illness to be managed; these ideas are explored further in following chapters.

2.2.3: Medical Discourse and Social Discourse of Mental Illness

The dominant discourses related to mental illness, particularly in relation to how mental illness is understood, generally fall within either a medical or health-based discourse, or a social discourse; in New Zealand, these discourses interact and influence the public and policy responses to mental illness. There is growing pressure from mental health professionals and advocates in New Zealand to see mental illness as an experience larger than health that needs to be addressed by more than just medical interventions, a wider social response is needed (Health and Disability Commissioner, 2018a; O’Hagan, 2018; The Government Inquiry into Mental Health and Addiction, 2018). The recent *He Ara Oranga* report, commissioned by the New Zealand Government, was mandated to explore mental

illness beyond the health sector, and attempt to apply a holistic approach to mental illness and addictions through examining other sectors and also the social and contextual circumstances surrounding mental illness and addiction (The Government Inquiry into Mental Health and Addiction, 2018). The *He Ara Oranga* report noted some of the social and contextual causes of mental illness, highlighting poverty, unemployment, and low-paid work, illustrating the relationship between economic context and mental illness (The Government Inquiry into Mental Health and Addiction, 2018). Lack of affordable housing, social isolation, family violence, trauma, abuse, and cultural alienation were also listed as factors that can contribute to mental illness (The Government Inquiry into Mental Health and Addiction, 2018). In a New Zealand context the impact of inequality on mental illness is starkly illustrated by the incidence of mental illness in the Māori population, reflecting the impact of colonisation on Māori, which has contributed to social deprivation and a greater inequality experienced by Māori (Health and Disability Commissioner, 2018a; Ministry of Health, 2016).

Despite increasing critique of predominantly medical or health based responses in some New Zealand reports including the *People's Mental Health Report* (Elliot, 2017), the *Health and Disability Commissioner's 2018 Report* (Health and Disability Commissioner, 2018a), and *He Ara Oranga* (The Government Inquiry into Mental Health and Addiction, 2018), mental health services and social practices still reflect a medical discourse. For example, mental health related prescriptions for medications have increased by 50% in New Zealand in the last 5 years (Health and Disability Commissioner, 2018a). This is despite the fact that there is growing awareness and understanding of the social determinants of mental illness, including the realisation that these may be related to an experience of inequality (Health and Disability Commissioner, 2018a; Pickett & Wilkinson, 2018). Partially, the continuing emphasis on medical responses to mental illness is due to a lack of funding for alternative treatment options (Health and Disability Commissioner, 2018a). While the social and contextual discourse of mental illness is present in New Zealand and has contributed and continues to contribute to the resistance of the medical discourse of mental illness, the dominant discourse and response to mental illness still appears to be medical or health-based, in terms of health structures and service provisions.

2.2.4: Recovery- Oriented Mental Health Structures

Recovery is another significant discourse surrounding mental illness that has influenced the policy and service provision for mental illness in New Zealand. In 1998, the New Zealand Mental Health Commission proclaimed the benefits of recovery-orientated services, making New Zealand a forerunner in recovery-orientated services (O'Hagan, Reynolds, & Smith, 2012). The concept of recovery is problematic to define, but is frequently described as living a meaningful life despite the symptoms of mental illness; this is said to be achieved through self-management and self-knowledge, a highly individual journey (Anthony, 1993). Although in New Zealand, the originally American concept of recovery has been critiqued due to the focus on the individual, in New Zealand, service provision has been adapted to place a greater emphasis on collective or whānau responses to mental illness, better reflecting Māori values (O'Hagan et al., 2012).

The impact of recovery discourse on mental health structures in New Zealand is difficult to evaluate, in part because it is a highly individual concept and also in part because as O'Hagan et al. (2012) noted, recovery is not a concept that is currently in favour within state services. Within the recent *He Ara Oranga* report, the concept and discourse of recovery was not mentioned (The Government Inquiry into Mental Health and Addiction, 2018). The discourse and strategies of recovery are more present in non-government organisations (NGOs) providing mental health services in New Zealand (O'Hagan et al., 2012). The concept of recovery will be explored in detail in subsequent chapters, as it is has been a prevalent concept particularly in mental illness literature.

More recently, within New Zealand, the influence of the recovery discourse appears to be diminishing in influence, being replaced with more Māori understandings of mental illness and well-being. The four dimensions of Māori well-being incorporated in the Te Whare Tapa Whā model developed by Durie (2011), relate to key Māori understandings of mental illness. The four dimensions outlined within Te Whare Tapa Whā are: taha wairua (spiritual health), taha tinana (physical health), taha hinengaro (psychological health) and taha whānau (family health); this model reflects a kaupapa Māori or Māori approach and understanding of mental illness, which may be replacing recovery discourse (O'Hagan et al., 2012). The recovery discourse also appears to be replaced by the concept and discourse of well-being, which were promoted within the *He Ara Oranga* report (O'Hagan et al., 2012; The Government Inquiry into Mental Health and Addiction, 2018).

2.2.5: Well-Being Discourse and Strategies

The discourse of well-being is promoted within the *He Ara Oranga* report as a way to expand beyond a medical and health based approach to mental illness to one that includes more social determinants of mental illness (The Government Inquiry into Mental Health and Addiction, 2018). Well-being discourse is also embedded within employment, and several public health campaigns in New Zealand including ‘Mental Health Awareness Week’ and ‘Pink Shirt Day’, the latter of which is an anti-bullying campaign which includes workplace specific content, are strengthening the discourse of well-being in the workplace (Mental Health Foundation New Zealand, 2018c)

Well-being strategies in workplaces are linked in part to a neoliberal, economic drive for productivity; any number of apps, workshops, and self-management strategies are promoted as a means for increasing staff happiness and simultaneously increasing productivity (Hall, 2018). Work life balance policies or flexible work policies are part of this discourse as well, with flexibility being highlighted as a necessary component of an ‘employee friendly’ workplace (Fleetwood, 2007). The discourse of workplace well-being, which draws on concepts such as flexible work and work life balance, has been accused of replacing concerns over worker’s rights and structural responses to workers’ issues within employment settings (Lewis, Gambles, & Rapoport, 2007). Workplace well-being discourse places the responsibility of maintaining well-being and managing work and other life commitments firmly on the individual employee, suggesting that if an individual is stressed and overwhelmed, then they should attend the mindfulness workshop provided or a yoga class (Hall, 2018). A workplace no longer needs to take collective responsibility for the work demands or work structures that may be creating stress for employees as their flexible work policies mean that individuals should be able to manage all their commitments (Lewis et al., 2007). Within New Zealand and other neoliberal states internationally, there is a greater number of services being provided to support work place well-being, as illustrated in New Zealand’s public health campaigns, which is partially supported through neoliberal discursive frames that focus on individual responsibility, and the importance of productivity.

2.3: Employment and Economic Discourse in New Zealand

There are several dominant discourses that are relevant to understanding the experience of work for individuals with mental illness, as well as the experience of work broadly in New Zealand. This section specifically examines the workfare discourse in New Zealand and discourse on the importance of work. This is followed by a consideration of discrimination and stigma discourse and how this relates to disclosure in the workplace. Next, discrimination, rights discourse, and disability discourse are discussed. Discourse that relates to economic and employment matters illustrates the ways in which individuals with mental illness and wider society experience work and economic pressures, and helps to contextualise the findings within Chapter Six.

2.3.1: Welfare to Workfare State

Within the context of mental illness, discourse about work related policies and service interventions frequently posits work as a means of supporting recovery (Gordon & Peterson, 2015). Work is framed as a positive experience for individuals with mental illness, positively impacting their financial circumstance, their social experience, and their sense of confidence (Peterson, 2007). Being unemployed or not in work, is conversely seen as having a negative impact on an individual's mental state, due in part to poverty, isolation, loss of structure, and lack of purpose (Gordon & Peterson, 2015). For example, Mental Health Foundation of New Zealand reports on positive work experiences in open employment of individuals with mental illness and on disclosure in the workplace identify work as both a solution and a desirable experience for individuals with mental illness (Gordon & Peterson, 2015; Peterson, 2007). This discursive formation of work is also the discourse embedded within the welfare restructuring that has taken place in New Zealand and globally.

Since the 1990s, the New Zealand welfare structure has been reformed through a discourse that challenges dependency, and places an emphasis on the positives and importance of work (O'Brien, 2013). Politicians and media portrayals have described previous welfare structures as structures that have created dependency, with dependency being framed as a significant failing of individuals on a benefit and costing the government (Beddoe, 2014; O'Brien, 2013). O'Brien (2013) argued that how welfare is understood in New Zealand and globally is part of a neoliberal discourse, which has impacted both social and economic policy, particularly in that it has become increasingly focussed on individuals and on individuals responsibility,

while moving away from the collective or shared responsibility of the state and society (O'Brien, 2013).

Recent reforms to Work and Income New Zealand (WINZ), which is the social welfare agency of New Zealand, has meant that welfare has become conditional on a willingness to work. A number of types of benefits, including the sickness benefit and the invalids benefit, were replaced by the Jobseeker Support Benefit in 2013, illustrating the impact of the emphasis and discourse of work within welfare structures in New Zealand (Gordon & Peterson, 2015). In 2010, The Welfare Working Group, alongside the government, argued that individuals on a sickness benefit, invalids benefit, or a sole parent benefit, wanted to work and therefore should be supported to do so, however, this was discussed without any examination of the labour market, specifically the availability of flexible and accommodating employment opportunities (O'Brien, 2013). The discourse of work and employment embedded within the New Zealand welfare system does not acknowledge the work structures and economic systems that influence individuals' abilities to access employment, which is particularly relevant for individuals with mental illness and disabilities who are likely to experience discrimination in the workplace (Soldatic & Chapman, 2010).

2.3.2: Discrimination, Stigma, and Disclosure

Despite public anti-discrimination and awareness-raising campaigns, discrimination and stigma are still common experiences of individuals with mental illness. A New Zealand study undertaken in 2003, found that 34% of 785 participants surveyed had experienced discrimination while looking for work (Peterson, Pere, Sheehan, & Surgenor, 2007). The stigma and discrimination of mental illness relate strongly to historical and media-influenced discourses of mental illness, which frequently portray mental illness as risky, dangerous, and often occurring in association with criminal activity (Coverdale, Nairn, & Claasen, 2002). In terms of employment, mental illness is portrayed as having a negative impact on productivity (Krupa et al., 2009). Participants in another research study conducted in New Zealand (Peterson, 2007), stated that discrimination was experienced both in applying for jobs and within employment and received from employers as well as colleagues.

The full impact of discrimination towards mental illness in the workplace is difficult to assess as oftentimes individuals will choose not to disclose their mental illness to avoid discrimination (Irvine, 2011; Krupa et al., 2009). The fear of discrimination is as limiting as

the experience of discrimination itself; 46% of 785 participants surveyed in the study conducted by Peterson et al. (2007) stated that they would chose to not do things to avoid discrimination, including not applying for certain jobs and also avoiding social engagements. Despite the common experience of discrimination in the workplace, within a 3 year period only 69 formal complaints were made to the Human Rights Commission of New Zealand on the grounds of discrimination against a psychiatric disability in employment settings (Gordon & Peterson, 2015). This may be in part because individuals with mental illness feel unable to advocate for their own rights due to self-stigma, low self-esteem, or simply not having the personal resources to manage a legal process on top of managing their own experience of their mental illness.

For individuals with mental illness, disclosure is an ongoing dilemma in the workplace, with common questions including whether to try to pass as ‘normal’ and manage the stress of hiding a stigmatised identity, or, conversely, to reveal their disability and in doing so either access support in the workplace or alternatively be discriminated against (Clair, Beatty, & Maclean, 2005; Irvine, 2011). Ragins (2008) and Krupa et al. (2009) noted that individuals with mental illness struggle with managing their secret in the workplace, and often experience considerable stress and fear of being caught or outed in some way. While the fear of discrimination may prevent disclosure, Clair et al. (2005) observed that some prefer to manage the risk of discrimination in order to be authentic and not have to maintain a secret or masked identity at work. Elraz (2018) and Corrigan and Matthews (2003) additionally noted that some individuals will choose to disclose their mental illness as a political or social act, to encourage others to do the same and to promote change in their workplace and in wider society. However, for individuals, determining how to engage with disclosure is a very challenging decision, involving managing the risks, particularly risks posed by discrimination that could result in job loss.

2.3.3: Discrimination, Disability, and Rights

The discrimination and stigma attached to mental illness can influence the employment outcomes of individuals with mental illness; alongside this, beyond public campaigns, there is a lack of advocacy and systemic approaches to ensuring the rights of individuals with mental illness in the workplace. In New Zealand, the *Human Rights Act* was passed in 1993, legislating that it was illegal to discriminate against an individual based on their disability in

relation to education, housing, access to goods and services, and employment (Peterson et al., 2007). Disability law and human rights legislation have decreed that individuals with disabilities must not be discriminated against due to their disability and that within the workplace reasonable accommodations must be made to support individuals with disabilities (Dargan, 2016; Shuey & Jovic, 2013). As Shuey and Jovic (2013) observed, reasonable accommodations ensure that individuals are protected from the negative effects that their disability may have on employment outcomes. Examples of reasonable accommodations generally include flexible working arrangements, whereby individuals may work less hours, perform the work in alternative ways, or work from home (Shuey & Jovic, 2013). However, while legislation aims to protect individuals with disabilities, Krupa et al. (2009) and Shuey and Jovic (2013) argued that there is inconsistency and lack of guidance about how employers should enact reasonable accommodations; equally there are few negative consequences for employers who choose to not provide reasonable accommodations to avoid cost or because they do not see the accommodations as essential to an individual's role. Krupa et al. (2009) noted that this particularly impacts individuals with mental illness as it is harder for an employer to understand the accommodations an individual with mental illness needs compared to an individual with a physical disability.

The requirement to provide reasonable accommodation, while seen as part of civil rights for individuals with disabilities, is not without criticism and concern. Jammaers et al. (2016) argued that while asking employers to provide reasonable accommodations does diminish barriers for individuals, it also inherently maintains and does not challenge the 'ableist' norms of work environment and work structures. Schur et al. (2014) stated that the idea of accommodations should be applied to all employees, as most accommodations require flexible work settings which can support everyone's work, and approaching accommodations in this way avoids discriminatory social discourse. Jammaers et al. (2016) highlighted that individuals with disabilities can be perceived to be gaining 'special privileges' in the workplace, which can make them vulnerable to criticism from colleagues and employers. However, Ingram (2006) noted that how disability was understood in an employment setting and within policy impacted how the practice of reasonable accommodations or support for individuals with disability was constructed. Ingram (2006) observed two main constructions of how society chooses to respond to individuals with disability: a welfare approach, which compensates people with a disability for their inability to conform to society, and a civil rights approach, which engages society to make changes so that persons with disabilities can

be part of society. In New Zealand, disability, particularly in relation to employment accommodations, is responded to through a welfare approach, although in relation to mental illness this is often not happening due to a lack of disclosure (Peterson, 2007), and also due to a lack of advocacy in relation to rights of individuals with mental illness in the workplace (Gordon & Peterson, 2015).

2.4: Conclusion

This chapter has outlined some of the dominant historical and contemporary discourses embedded within the mental health system and economic structures of New Zealand. The various and sometimes contradictory discursive frames surrounding mental illness lead to somewhat confused understandings of the experience of living with and managing mental illness. These discursive frames surrounding mental illness in New Zealand also shape the experience of mental illness as well as the subject identity of having a mental illness. How mental illness is constructed by government services, within public health campaigns, in reports, and in the media in New Zealand impacts the lives and identity formations of individuals with mental illness. Similarly, the complex economic discourse, the discourse on work, as well as disability discourse and rights discourse highlight the complicated economic and socio-economic realities that individuals with mental illness have to navigate in New Zealand. The following chapter expands on some of these themes, examining the relevant literature and research from New Zealand and elsewhere.

CHAPTER THREE: LITERATURE REVIEW

3.1: Introduction

This chapter examines literature relevant to the research topic, focussing on mental illness research literature as well as economic and employment research literature, in order to see how this fits within a wider study of mental illness and employment discourse. The process of completing a review of relevant literature helped to further identify the gaps in knowledge that this research project could fill.

Within this review, I examine literature from New Zealand, the United Kingdom (UK), Australia, the United States (US), as well as European literature. Discourse analysis is the predominant methodology used within the research literature discussed in this chapter, however, other methodological approaches focusing on topics that are highly relevant have also been included. Also, the methodological approach of discourse analysis was interpreted differently within the literature, with some researchers applying a more linguistic understanding of discourse analysis while others focused on Foucauldian discourse analysis, although even within Foucauldian discourse analysis there were different approaches highlighted.

This chapter begins by focussing on normative discourse and identities discussed in the literature and how normative discourse impacts individuals and groups that are seen as ‘non-normal’. Following this, discursive formations surrounding mental illness are examined in terms of how these have been considered in the literature, looking at research from numerous discursive perspectives including: medical, health, or technical discourse, social and contextual discourse, disability discourse and rights discourse, and recovery discourse. The following section highlights the economic discourse and discursive formations surrounding work, beginning with an examination of how various authors have considered the impact of neoliberalism on the role of the state and state services. Building on this review of neoliberal discourse, the discussion moves on to consider how the importance of work has been narrated, as well as how the impact of stigma and discrimination in the workplace on work opportunities and outcomes of individuals with mental illness has been constructed in the literature. The literature on disclosure and on unemployment discourse is also examined, as well as literature on welfare reform, and individual employability. This literature review

covers a wide range of themes, illustrating the complexity of this research topic but also creating a broad picture of the current research being undertaken on this subject. The review of literature helps position my discourse analysis study within the field.

3.2: Normative Discourse: Normal and Non-Normal Identities

Within the literature examined in this section, there are discussions about how normative and non-normative behaviours, ways of being in the world, and ways of thinking are constructed, particularly in relation to the social norms within workplace contexts but also in wider social contexts. This literature is relevant to examine as subject identities associated with the discourse of mental illness and similarly identities associated with disability, are often seen as deviant from the social norm and placed in contrast to the desirable subject identities of ‘normal’ citizens. The dichotomous discourse that contrasts ‘normal’ and ‘non-normal’ underpins many other discourses that are discussed further in this chapter. The assumption and social construction that there is a correct way to be, whether that is at work or in other social settings, is what Foucault described as a discursive formation embedded within society; one that seems so rational, that its truth and validity is taken for granted (Graham, 2011; Nicholls, 2009). Individuals with mental illness, and similarly individuals with other disabilities, have subject identities that are constructed as ‘non-normal’; the literature examines discourse regarding this and also highlights the constructed identity of the ‘ideal worker’ which is often an unattainable position for individuals with mental illness.

3.2.1: Normative Discourse: A Non-Normal Identity

The literature highlights numerous social realities, practices, and experiences within the construction of mental illness and of work, however, dominant discourse is frequently underpinned with ‘normative’ discourse, or a way to be in the world that is considered ‘normal’, which is contrasted with the ‘non-normal’ behaviours and experiences surrounding mental illness. Randall and Munro (2010) and Jammaers et al. (2016) emphasised how discursive formations create the concept of a ‘normal individual’; this discourse influences society’s perceptions of acceptable behaviours and acceptable ways of thinking. The research conducted by Randall and Munro (2010) examined the perspectives of mental health workers, including doctors, counselors, and community psychiatric nurses in a region of Scotland.

Randall and Munro (2010) noted that through the organisational practices of mental health workers, these 'experts' often exercise disciplinary power that maintains and regulates 'norms'. Similarly, Jammaers et al. (2016) identified a dominant discourse of 'normal', specifically in the workplace, and observed how this discourse simultaneously constructs subject identities perceived as inferior or 'non-normal', for example, individuals with disabilities and individuals with mental illness. Many of their participants with disabilities noted a tension between what they were expected to produce in the workplace and what they were discursively deemed unable to do through their disabled subject identity (Jammaers et al., 2016). However, Randall and Munro's (2011) research also revealed that while mental health workers' roles may use normalisation techniques to attempt to restore individuals to 'normal' behaviour, most of the 11 workers they interviewed were critical of their roles in the labelling of 'abnormal' and 'deviant' behaviour, and how this could lead to a self-fulfilling prophecy for individuals experiencing mental illness. Randall and Munro (2011) noted that therefore, while these professional 'expert' roles and mental health workplaces are embedded with practices of normalisation and expectations of normal levels of productivity and behaviour, professionals within mental health do also critique the process of normalisation and the dominant discourse of 'normal'.

Similarly, individuals with mental illness can frame their subject identities in more positive ways. Elraz (2018) research indicated that while discursive formations create particular subject positions, this does not mean that individuals passively accept the subject position of being 'non-normal' or inferior; individuals have access to numerous, sometimes conflicting discourses to influence their understanding of their identity and often take on multiple subject positions depending on the social context. Elraz (2018) also drew on Foucauldian discourse analysis in order to examine the impact of discourse on individuals' identities and how they managed a stigmatising, non-normal discourse. Elraz (2018) interviewed 32 individuals with mental illness who were working in the UK and found that individuals frequently resisted or adapted negative discourse of mental illness, reframing non-normal discourse to construct a positive subject identity for themselves in the workplace.

Similar to Elraz (2018), Anspach (1979) noted that individuals have a choice to accept or reject discursive formations constructing their social identity. Anspach (1979) examined disability and mental illness in relation to politics and social movements and how these affected the formation of identity of individuals with disability and individuals with mental illness and their engagement with society. According to the model set out by Anspach (1979),

there are four different ways that individual subjects can construct their identity and their engagement within the social and political context, through: normalising, political activism, retreatism, and disassociation. Normalisation and political activism are seen as positive strategies of engaging with a ‘non-normal’ identity, whereas retreatism and disassociation are termed negative ways of engaging with identity (Anspach, 1979). However, while an individual may choose to reframe or resist hegemonic, dominant discourse that discriminates or stigmatises their identities, individuals with mental illness and disabilities may struggle to achieve this. Discursive formations and social practices constructing what is ‘normal’ are so embedded within society that the experiences and realities of non-normal individuals are frequently excluded and silenced by normative society (Anspach, 1979).

3.2.2: Normative Discourse: The Ideal Worker

One particular area where discursive formations of ‘normal’ impact the experience of individuals with mental illness is at work; society has a normative ideal of a good worker and this impacts the experience of anyone who does not fit that ideal. Jammaers et al. (2016) and Foster and Wass (2013) highlighted how the subject identity of the ideal worker was frequently constructed by ableist, able-bodied discourse. Foster and Wass (2013) examined four cases between employers and employees within the Employment Tribunals in the UK, specifically incidences where employers had failed to make ‘reasonable accommodations’ for employees as based on the *UK Equality Act 2010*. Both employers and employees within these cases had argued that the job descriptions and workplaces were standardised and designed to fit the ‘normal’ worker, making it difficult or unlikely for employers to accommodate a ‘non-normal’ employee (Foster & Wass, 2013). Non-disability is assumed to be the norm for the worker within social practices, work formations, and institutions; all of these are constructed around a normative discourse of ableism or the discourse of ‘normal’ (Jammaers et al., 2016).

While work and the market are seen and described as ‘neutral’ contexts, Foster and Wass (2013) argued that they are in fact inherently discriminatory and will exclude those different from the ‘norm’ or those that are not able to fulfil the subject position of the ‘ideal worker’, in order to maximise efficiency and standardisation. Elraz (2018) and Jammaers et al. (2016) emphasised that individuals with disabilities and those with mental illness are frequently represented as being incapable of work, unreliable at work, unsafe at work, and less

productive at work, and are therefore systemically excluded from work settings. This discursive formation creates a devalued and negative subject position for individuals with mental illness or disability, which individuals then have to choose to accept, reject, or adapt to their own sense of self and self-worth in society (Jammaers et al., 2016). Southern and Miller (2012) observed that individuals with mental illness frequently have to adapt their work identities and their expectations of their work lives. Their New Zealand based, qualitative study, used discourse and narrative analysis to examine the experience of 15 women with mental illness in relation to their diagnosis, recovery, and employment outcomes. The women with mental illness in this study were found to have their work identities challenged due to the physical and social impacts of their mental illness and the discursive formations surrounding that illness (Southern & Miller, 2012). Within the literature, we can see that mental illness and disability inherently challenge normative workplace discourse and the social practices associated with this discourse, for example job standardisations and job application forms.

Productivity is a particular aspect of work identified in the literature as a source of strain and stress on individuals with mental illness or disability, specifically not being seen as able to be productive enough or working hard enough as a 'normal' or 'ideal worker' to fulfil the market expectations of work (Elraz, 2018; Jammaers et al., 2016; Lantz & Marston, 2012). Within the research conducted by Lantz and Marston (2012), based in Australia, 80 individuals accessing welfare benefits were interviewed two times over a period of 2 years to examine the impact of the change in welfare policy in the individual's experiences. The research found that individuals had accepted the discursive frame around their lack of employment being their individual responsibility, stating that they needed to work hard on themselves to be more employable and to be seen as 'normal' and skilled by market standards (Lantz & Marston, 2012). However, participants also observed that discrimination and stigma created additional obstacles for them (Lantz & Marston, 2012). This tension between individual responsibility, and the individual's need to be employable and productive, and seen as fitting 'normal' workplace standards versus the social reality of oppressive and discriminatory work environments, was a strong theme within the literature and one that is explored further in a later section of this chapter on work discourse. It is important to note that difference, non-normal, and the stigmatised identity of mental illness mean that engaging in society and within work settings is inherently challenging for individuals with mental illness. While, broadly, the discourse of mental illness constructs a non-normal subject

identity, there are specific discursive formations surrounding mental illness which construct and shape how society makes sense of mental illness and responds to it and this is examined further in the next section.

3.3: Discursive Formations Surrounding Mental Illness

The discursive formations surrounding mental illness determine both how society responds to mental illness and the treatment of individuals with mental illness (Ringer & Holen, 2016). The discourse of mental illness is constantly negotiated within work settings and within mental health practice settings, as there are numerous and oftentimes contrary perspectives regarding mental illness interacting and embedded within social structures. Ringer and Holen (2016), using Foucauldian discourse analysis on ethnographic data from two mental health institutions in Denmark, revealed that mental illness was defined and performed differently depending on the discourse being enacted within those particular settings. Even within two mental health institutions in Denmark, slightly different discursive frames were embedded within the context and influenced the treatment and social practices performed within those contexts (Ringer & Holen, 2016). Some perspectives, as highlighted in the following section, are more present within particular professional settings such as mental health services, whereas others may be more present in media portrayals and discussions of mental illness, and some are more present within administrative or legislative understandings of mental illness. The following section considers four dominant discursive formations of mental illness: the medical, technical and health based discourse of mental illness, the social and contextual discourse of mental illness, disability discourse related to mental illness, and finally recovery discourse.

3.3.1: Medical, Health, and Technical Discourse of Mental Illness

Perspectives on mental illness are varied and interrelated, however, the extant literature confirms the dominance of medical, technical, and health-based discourse of mental illness, particularly within mental health services but also within the media, and wider social and historical understanding of mental illness (Dobransky, 2009; Klevan, Karlsson, Ness, Grant, & Ruud, 2018; Rhys Price-Robertson, Obradovic, & Morgan, 2017). The dominance of the medical framework for understanding mental illness is in part due to the structures

reinforcing this discourse, particularly funding streams as noted by Dobransky (2009). In a study of two mental health organisations conducted by Dobransky (2009), analysis found that labelling mental illness in accordance with medical discourse was an essential aspect of organisational practice that was undertaken in order to receive funding as funding frequently favoured medical diagnosis and intervention. Within the mental health organisations in the study, which was based in the United States, formal medical labels and medical discourse were found to be less used and seen as less useful in everyday running of the organisations but when engaging with state funding and state formal processes, a more medicalised and formal discourse was used and seen as necessary (Dobransky, 2009).

Mental health organisations tend to have complex discursive formations of mental illness interacting within the same context. This is influenced in part by discourse embedded within powerful structures, such as government funding structures, as seen in the research undertaken by Dobransky (2009), and also embedded within professional, mental health knowledge as observed by Klevan et al. (2018) in their study. Klevan et al. (2018), in a discourse analysis of two mental health crisis resolution teams in Norway, identified two distinct and contrary discursive formations relating to the professional identity and practices of the crisis teams. The mental health workers and clinicians framed their roles in either of two ways. Within a ‘help as made’ discourse, they framed their work as being co-constructed with clients; a new way of working was led by the client and the social and environmental context of the client (Klevan et al., 2018). If, instead, they framed their work within a ‘help as given’ discourse, which described professional knowledge and expertise as being needed by clients, then efficient assessments and structures were perceived to be arrived at through pre-determined processes of engagement with clients that gave reliable results (Klevan et al., 2018). The expert, professional knowledge, or ‘help as given’ as described by Klevan et al. (2018) is a decontextualised, medical discourse, which relies on the use of the disciplinary power of experts, as described previously, to manage deviant behaviour and thinking. This discursive frame is similar to what Grant (2015) described in an article on mental health nursing, as the ‘technical’ discourse of mental illness. This discourse is by no means the only discourse embedded within mental health settings, but it is a dominant discourse which alternative discourses have been challenging over the course of decades and one that is still embedded within professional roles in mental health settings.

Medical understandings of mental illness are typified by an assumption that diagnostic biological criteria and empirical measures can be used to observe and define mental illness

(Keyes, 2005; Lieberman & Ogas, 2015). In this way, mental illness is constructed as an internal experience that can be identified and treated, unrelated to contextual factors, often disembodied from the subjective experience and realities of individuals (Grant, 2015). This perspective of a medical or technical paradigm, as described by Grant (2015) and Klevan et al. (2018), forms mental illness as internal, with biological causes to be treated through biomedical interventions. Klevan et al. (2018) observed that a technical discourse is the dominant discourse within mental health services primarily because it privileges expert knowledge and is efficient and able to be standardised. Technical and medical paradigms are difficult to resist within mental health services as these also serve neoliberal considerations of efficiency and cost-effective interventions (Grant, 2015). Neoliberal discourse is explored further within the review of literature on work and employment discourse.

While medical understandings of mental illness embedded within mental health services are often portrayed as creating negative or stigmatised subject identities for individuals with mental illness, Schreiber and Hartrick (2002) found in their research that individuals with mental illness also often explain their mental illness in terms of a medical paradigm and find some relief in this explanation. Schreiber and Hartrick (2002) observed that most of the 43 women interviewed in their research adopted a medical explanation for their experiences of depression, despite most of them not having success with the medical treatments that were prescribed. Schreiber and Hartrick (2002) noted that the participants adopted the medical paradigm in part due to participants feeling less self-stigma knowing that they had a biological illness rather than that they were ‘just lazy’ or somehow ‘bad people’. Participants also adopted the medical discourse because of the authority and dominance that the medical discourse had in society, making it difficult to understand mental illness outside of that framework (Schreiber & Hartrick, 2002). While other literature, which is explored further in the following section, has suggested that individuals with mental illness tend to frame their experience of mental illness within social or contextual understandings, the research by Schreiber and Hartrick (2002) illustrated that medical and technical discourse can offer relief to individuals with mental illness.

The primary tool for defining mental illnesses and the symptoms of mental illness within a medical and technical discourse is through the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) (Esposito & Perez, 2014; Lieberman & Ogas, 2015). The ability to define mental illness and the symptoms associated allows a prescription of medical treatments (Esposito & Perez, 2014). Esposito and Perez (2014) and Crowe (2000) argued the DSM

articulates and legitimises the discourse of ‘normal’ by illustrating the range of human behaviours and ways of thinking that are deemed ‘non-normal’ or an ‘illness’. Esposito and Perez (2014) discussed in their article how the DSM has contributed to the medicalisation of human experience, and, alongside the medical discourse of mental illness, they observed the neoliberal discourse of consumerism embedded within the pharmaceutical industry, which again reinforces a medical discourse of mental illness. It could be argued that a medical understanding of mental illness is particularly dominant in a US context as the pharmaceutical industry has greater power and faces less regulatory constraint there than in other contexts, as claimed by Esposito and Perez (2014). However, the impact of the DSM and how it constructs professional knowledge, particularly psychiatric knowledge but also other mental health professional knowledge, impacts on a global scale. Crowe (2000) undertook New Zealand based research on how the DSM constructs ‘normality’. Crowe (2000) suggested that the DSM constructs ‘normal’ human behaviour as behaviour that is rationale, productive, moderate, and has unity, whereas other behaviour can be seen as deviant and have a diagnosis attached to it. While the validity of the DSM (now in its fifth edition) and more broadly the medical perspective as a whole, were critiqued within the literature, as Dobransky (2009) noted, this medical discourse still remains embedded within social practices, specifically funding allocations, and in common social understandings of mental illness.

There is growing critique toward the medical and technical discourse of mental illness, particularly with regards to how this privileges the ‘expert’ medical professional subject positions within mental health settings and fails to examine the potential contextual or environmental causes of mental illness (Esposito & Perez, 2014). Nairn and Coverdale (2005) noted that media items often feature ‘expert’ medical professionals who comment on ‘non-normal’ behaviour, particularly in relation to criminal behaviour. However, Ohlsson (2018), in his discourse analysis research of media items published in Sweden in 2009, observed a growing critique towards ‘experts’ and ‘expert knowledge’ in relation to mental illness. Alongside this emerging critique of medical experts noted by Ohlsson (2018), there is a growing critique within the literature of medical responses to mental illness. Esposito and Perez (2014) argued against the medical construction of mental illness as it limits the responses to mental illness to medicine and medical treatments. Most participants in the research conducted by Schreiber and Hartrick (2002) and Bond and Meyer (1999), despite having had mixed success with medications and having struggled with side-effects of

medications, still articulated medication as their primary treatment. According to Appignanesi (2011) and Esposito and Perez (2014), this narrow range of how mental illness is treated and understood can mean that aspects of human behaviour are prescribed medications when they may actually need to be addressed through social and political action.

3.3.2: Contextual and Social Discourse

Contextual discourse of mental illness focusses on the subjective and social experiences of mental illness rather than the objective, symptom-based, medical experience of mental illness (Fletcher, 2018; Tran Smith, Padgett, Choy-Brown, & Henwood, 2015). Grant (2015) described contextual discourse as being part of the ‘human paradigm’ of mental illness; an understanding that mental illness and mental health are based on human relationships and subjective experiences, as well as social and cultural contexts and experiences of individuals. Within Fletcher’s (2018) research, it was highlighted that there is a need for new metaphors, language, and frameworks around mental illness in order to expand from the narrow parameters of the medical paradigm and offer alternative, more subjective explanations that resonate with individuals who experience diverse mental states. Fletcher (2018) undertook an ethnography on the Icarus Project in the United States, a radical mental health community that operates online and with face-to-face peer group discussions, observed a resistance to the psychiatric/medical explanation and understanding of mental illness in online communities. Resistance to the medical discourse of mental illness, as Conrad and Schneider (2010) and Braslow (2013) observed, initially developed in the 1960s and early 1970s with the rise of the de-institutionalisation, antipsychiatry, and psychiatric survivors movements. These movements questioned the causes of mental illness and the best treatment of mental illness, and since this time there has been growing interest in alternative understandings and approaches to mental illness.

Research and literature place growing emphasis on context and social aspects contributing to the experience of mental illness. As Ewart et al. (2017) observed in their recent study on the physical health of individuals with mental illness in Australia, participants stressed the importance of the material, economic, and social conditions impacting their lives and their mental health above their particular symptom experiences. The context of individual participants’ lives had a huge impact on their overall health, with economic factors playing a particularly significant role as poverty, due to lack of employment, impacted participants’

ability to access health services (Ewart et al., 2017). A World Health Organisation article argued that poverty and rising levels of relative inequality constitute the greatest cause of suffering globally (Murali & Oyeboode, 2004). Similarly, Kokaliari (2018) argued that this could be clearly seen in the experience of Greece after the 2008 financial crisis, illustrating the relationship between economic circumstances and mental illness. In Greece, within three years of the 2008 financial crisis, approximately 10 million people lost their employment and within that same timeframe suicide increased by approximately 27% (Kokaliari, 2018). Kokaliari (2018) conducted several surveys with 901 adults living in Greece, measuring their quality of life and their levels of depression, anxiety, and stress; the research found that the participants had a much higher rate of depression, anxiety, and stress compared to normal populations. The correlation between socio-economic status and mental illness has been consistently observed in recent studies. As noted by Murali and Oyeboode (2004) and Lund et al. (2011) and Kokaliari (2018), individuals living in poor communities, of lower social status, and on lower incomes are more likely to experience mental illness.

Recent literature has also explored the influence of place and community on the experience of mental illness, and how place can either support or hinder the subjective experiences of individuals with mental illness. Gonzalez and Andvig's (2015) review of articles on supported housing issues experienced by individuals with mental illness, highlighted how the experience of stable housing within a community contributes to belonging and social integration. Equally, however, poor housing conditions, discrimination in a community, and lack of easy access to facilities added additional stress and negatively impacted individuals with mental illness (Gonzalez & Andvig, 2015). Similarly, Tran Smith et al. (2015), in their research on place and recovery, observed how community participation and integration were an essential part of individuals with mental illness being able to reclaim a positive social identity. In their research on individuals with mental illness living in independent housing, Townley, Kloos, and Wright (2009) noted that, while individuals can make efforts to feel at home in a place through community participation, their integration, and sense of connection to place can be negatively impacted by a community's intolerance and discrimination towards individuals with a mental illness.

The growing interest in how place and other social, contextual, and environmental factors contribute to mental illness reflects a strengthening of social and contextual understandings of mental illness. The contextual experiences and understandings of individuals with mental illness offer alternative discourses and resistance to the dominant discourses of medical

understandings of mental illness (Fletcher, 2018; Randall & Munro, 2010). Even mental health professions and other health professionals, as highlighted by Randall and Munro (2010), are critical of their own effectiveness within a solely medical discourse of mental illness, frustrated with both institutional care which offers containment and control, and with community-based care which too often does not have sufficient resources to be effective.

3.3.3: Disability: Psychiatric Disability

While there is limited literature examining the experience of mental illness within the context of disability, it is important to examine the literature that explores both the similarities between mental illness and disability, and also consider why there is distance between these experiences and discourses. Mental illness, as noted by Elraz (2018), is thought to be the greatest cause of disability throughout the world. Within the *United Nations Convention on the Rights of People with Disabilities* (CRPD), mental illness is categorised as a psychiatric disability (Szmukler, Daw, & Callard, 2014). In spite of mental illness being labelled a disability, being legally connected to disability through the CRPD and other rights-based legislation, and having similar historical experiences, mental illness and disability are experiences that are often discussed separately in the literature and within society.

There are similarities within the social treatment and response to individuals with mental illness and those with disability. As noted by Baylies (2002), Soldatic and Chapman (2010), and Beresford (2000), historically both groups have been institutionalised and defined through medical discourse, experience discrimination, and are frequently categorised together legally and administratively for the purposes of social services. Despite the commonalities between mental illness and disability, there is a distinct separation between discourse and literature surrounding mental illness and those surrounding disability. Soldatic and Chapman (2010) noted that this separation is perhaps due to the rise of divisions generally within the disability movement. There has been renewed focus on impairments, highlighting the different biological impairments and how they impact lifestyle and the support needed (Soldatic & Chapman, 2010). Beresford (2000) and Szmukler et al. (2014) noted that mental illness symptoms are often episodic or temporary and therefore do not qualify as a disability in the same way that a lifelong impairment does.

Despite mental illness being disputed as a disability, within the literature and within society the disability movement and social model of disability have impacted the social and

contextual discourse of mental illness (Braslow, 2013; Conrad & Schneider, 2010). As noted by Beresford (2000), the disability movement and the social model of disability prompted and influenced resistance to medical discourse by individuals with mental illness and it is therefore important to briefly examine the literature explaining the social model of disability. Disability within the social model is understood to be caused by environmental or societal factors that inhibit individuals with impairments (Jammaers et al., 2016; Kayess & French, 2008; Soldatic & Chapman, 2010). Baylies (2002) defined impairments, whether they are intellectual, physical, sensory, or psychiatric, as the biological limitations that individuals may have. Disablement, Mulvany (2000), Baylies (2002), and Harpur (2012) argued based on the social model of disability, is society's failure to accommodate individuals with biological impairments. In this way, the disability movement highlighted the systemic oppression, discrimination, and exclusion experienced by individuals with impairments (Kayess & French, 2008; Soldatic & Chapman, 2010). The shift from a medical discourse of disability to a social discourse of disability, highlighted in the social model of disability, is a profound shift in discursive thinking, one that Anspach (1979) observed, politicised the experience of individuals with disability. Mulvany (2000) argued that further research and discussion is needed to strengthen the link between the social model of disability and mental illness, as the social model of disability can offer an analysis of social oppression, discrimination, and exclusion rather than a focus on the individual experience of mental illness.

Politicising the experience of disability led to the formation of the CRPD and other legal interventions that prohibited discrimination towards individuals with disabilities. These legal interventions, demanding rights and protections, influence and are applicable to individuals with mental illness. However, currently the research and literature examining the rights of individuals with mental illness is frequently limited to critiquing the power and coercion within numerous mental health acts around the world, including New Zealand (Gordon & O'Brien, 2014; Wand & Wand, 2013). Szmukler et al. (2014) examined the possible legal consequences of the CRPD as it interacts with the *Mental Health Act* 1983 in the UK, specifically how involuntary treatment could be against the rights outlined in the CRPD. Gordon and O'Brien (2014) similarly examined and suggested that the *Mental Health Act* 1993 of New Zealand needed to be updated to reflect the changing discourse of rights for individuals with mental illness. Understanding disability discourse and how it has impacted and continues to influence the experience of mental illness is important, particularly in

relation to work because disability discourse and rights have influenced the understanding of accommodation in the workplace.

3.3.4: Recovery

Literature about the concept of recovery has dominated research and writing on mental illness, although this appears to be changing, particularly in New Zealand (O'Hagan et al., 2012). While recovery has become a prevalent ideology and discourse in mental health policy throughout the world, this discourse is not without contention; in fact, the literature is frequently critical of recovery. The recovery movement defines 'recovery' loosely. Bonney and Stickley (2008) and Braslow (2013) argued it is an unclear concept, defined mostly in opposition to the medical discourse. The recovery movement has been influenced in part by the disability movement, deinstitutionalisation, and a social and contextual understanding of mental illness, as was highlighted by Bonney and Stickley (2008) and Watson (2012). The recovery movement began in the US in the 1990s and soon gathered support in the UK and New Zealand (Bonney & Stickley, 2008; Scott & Wilson, 2011). Given the prevalence of the recovery perspective in mental health policy currently, Braslow (2013) and Meehan, King, Beavis, and Robinson (2008) highlighted that it is important to understand what is meant by 'recovery' in the context of mental illness. Recovery in policy, recovery in research, and recovery in mental health settings have slightly different meanings and Watson (2012) argued that further research is required to understand how these meanings of recovery are constructed in different settings. However, Braslow (2013) argued that treatment for mental illness under recovery-orientated services and recovery policies does not look very different from previous treatment options within mental health services, and that the changes within service provision could be understood through a growing neoliberal discourse within service provision rather than through recovery discourse.

Anthony (1993) described recovery as a personal process defined by the individual. Anthony (1993) offered an exploration of the recovery concept and a vision of how it can be used within mental health systems and organisations. However, given that it is also a highly personal process defined by the individual, applying the process and practice of recovery to mental health systems becomes complex and varies significantly (Watson, 2012). An important feature of recovery, as noted by Anthony (1993) and Meehan et al. (2008), is that it is not synonymous with 'no symptoms', but rather indicates that individuals can learn to

manage their symptoms. Scott and Wilson (2011) examined the Wellness Recovery Action Planning (WRAP) programme within a New Zealand context, exploring the way in which WRAP, a recovery-orientated programme, encouraged particular health identities, specifically a self-responsible and self-managed individual. Scott and Wilson (2011) argued that part of the encouraged identity and discourse attached to WRAP and therefore to recovery, is embedded within a risk-management discourse in which individuals become experts at assessing and managing themselves as risks. Equally the constructed 'healthy' identity of the self-responsible and self-managed individual is constructed to participate in particular healthy lifestyle choices to better manage and be responsible for their health. Access to healthy lifestyle options, Scott and Wilson (2011) argued, is, however, intrinsically related to, and reflects social economic status. Recovery discourse and the practice of recovery can be seen to be embedded alongside other discourses, particularly neoliberal discourse, and risk-management discourse within mental health institutions and structures.

Alongside this idea of managing symptoms, Anthony (1993) and Meehan et al. (2008) stated that the process of recovery and management of symptoms can take place outside of any professional or medical intervention. To this extent, Bonney and Stickley (2008) argued that an individual with mental illness can shift their identity from 'sick' and needing professional help to managing their own illness with their natural supports and being empowered in the recovery process. Within this broad process of recovery, hope, and personal responsibility are two concepts that are consistently referred to in the literature (Davidson & Roe, 2007; Scott & Wilson, 2011). Hope in recovery, Bonney and Stickley (2008) stated, is the hope that an individual can still lead a satisfying and meaningful life regardless of their mental illness. This is contrary to the previous medical assessment of mental illness which, as noted by Watson (2012), held a pessimistic view of life outcomes, whereas recovery, Scott and Wilson (2011) stated, highlights hope. Personal responsibility in relation to recovery is a more contentious idea. Harper and Speed (2012) and Scott and Wilson (2011) argued that the emphasis on personal responsibility and self-management in recovery ignores potential systemic issues impacting individuals with mental illness. Anthony (1993) controversially placed the onus on the individual to "change their self-concept and attitudes" in order to achieve recovery. While this view importantly places recovery within the individual's control as opposed to a medical professional's, Harper and Speed (2012) argued that it places all the pressure on the individual to make necessary changes to lead a 'normal' life.

While the recovery movement is considered to be an empowering and positive movement for individuals with mental illness in much of the literature, Braslow (2013) and Harper and Speed (2012) argued that the recovery model follows a neoliberal ideology that transfers social responsibility onto often vulnerable individuals. Harper and Speed (2012) highlighted three prominent concerns with recovery discourse in mental health and an understanding of mental illness, namely: the continued individualisation of mental illness, the persistence of a deficit understanding of mental illness, and the lack of collective or social approaches to recovery. The individual view of recovery and the understanding of mental illness within recovery discourse hides structural and systemic inequalities that are contributing to the experience of individuals with mental illness (Harper & Speed, 2012). As highlighted previously, the personal responsibility within recovery does empower individuals, however, Braslow (2013) observed that governments have often commandeered the recovery rhetoric in order to cut funding to state services. The broad definition of recovery also means, Meehan et al. (2008) noted, that it is unclear what 'recovery-orientated' services and policy mean in practice. As recovery is a very personalised and unclear concept, it can be employed in different and sometimes contrary ways within policy and service provision.

Recent literature on recovery has sought to explore recovery beyond the concept of the individual managing their mental illness, addressing the individualistic discourse of recovery by looking at recovery from a collective, relational, or family perspective (Rhys Price-Robertson et al., 2017; Tse & Ng, 2014; Wyder & Bland, 2014). Rhys Price-Robertson et al. (2017) tried to offer a relational approach to recovery, having noted the consistent critique of the individualistic discourse within recovery. Rhys Price-Robertson et al. (2017) noted the importance of family, both dependants of individuals living with mental illness as well as other family members, highlighting that the recovery process of an individual is impacted by their family circumstances and the support they receive from family members. As Wyder and Bland (2014) similarly noted, mental illness and recovery does not happen in isolation; networks and relationships surrounding individuals have an impact on the recovery experience. Tse and Ng (2014) also observed the cultural impacts on recovery, particularly focusing on the differences in recovery experience on individuals from individualistic cultures and those from more collectivist cultural backgrounds. Literature exploring the recovery experience and discourse beyond an individual experience can be seen to challenge the neoliberal discourse embedded within recovery, offering some resistance to that dominant discourse.

3.4: Discursive Formations Surrounding Work and State: Neoliberalism

Neoliberal discourse is a dominant frame within western democracies and one that has heavily influenced the experience of work as well as the role of the state in the last 30 years (Harvey, 2006; Howard, Agllias, Schubert, & Gray, 2018; Kokaliari, 2018). Harvey (2006) and Whitworth and Carter (2014) argued that the naturalisation and normalisation of neoliberal discourse has been a project of western democratic governments since the late 1970s. Whitworth and Carter (2014) observed that neoliberalism is such a hegemonic discourse that it appears to be a natural process, rather than a discourse that governments continue to affirm, construct, adapt, and disperse. Whitworth and Carter (2014) in their analysis examined the discourse underlying the change in welfare provision in the UK using Foucault's concept of governmentality to look at the way in which government uses technologies of power to define truth. Harvey (2006) also examined and discussed the reforms made by governments following a neoliberal ideology, however, he examined these in a US context. Harvey (2006) argued that neoliberalism and neoliberal discourse have impacted and embedded themselves within state institutions, labour, ways of thinking, and social relationships. A neoliberal approach by the state is categorised by an emphasis on the market as a way of organising society. Having an efficient and growing economy is seen as a primary goal and in order to achieve this goal, governments have privatised services, deregulated market controls, cut state supports, and put in place social practices and policies to encourage individual responsibility (Harvey, 2006; Howard et al., 2018; Prince, Kearns, & Craig, 2006; Whitworth & Carter, 2014).

Neoliberalism has impacted the value of work in society, the literature argues, by placing market outcomes and market identities above social outcomes and social identities, which is particularly visible in the adoption of the workfare policy, replacing welfare within numerous countries including New Zealand. Research conducted by Howard et al. (2018) on workers at Job Services Australia and other relief agencies revealed that workers supporting individuals into employment emphasised a narrow view of work and unemployment. The 32 participants saw their roles as heroic, as removing barriers for individuals to find employment, however, they were also quick to blame clients who were unable to find work and none of the participants discussed the cycle of poverty, discrimination, or other aspects of the labour market that might impact an individual's employment outcomes (Howard et al., 2018). Lantz

and Marston (2012) highlighted the distrust and shame attached to individuals who do not sufficiently fulfil their economic identities; neoliberal discourse has formed prominent economic identities and subjects: the consumer, the customer, the taxpayer, the worker. In Lantz and Marston (2012) research which examined the experience of 80 people accessing disability benefits over the course of two years, welfare provision consistently coerced welfare recipients to be ‘productive’ and ‘active’ citizens through employment. Southern and Miller (2012) and Whitworth and Carter (2014) noted that individuals who find it challenging to secure and sustain work and fit within the economic subject as formed by the state, feel the impact of an inferior subject identity of being unemployed and are frequently confronted with less support and coercive paternalistic government processes.

3.4.1: The Significance of Work

The literature surrounding work or employment places great emphasis on the significance of work, and the centrality of work to society, to citizenship, and to well-being, which is reinforced by the neoliberal discursive formations embedded within society. Patrick (2012) examined the way in which work was seen as the activity of a good citizen in the UK, examining the rhetoric of policy and how it valorised work. Work is generally defined in the literature to mean paid employment. Noon, Blyton, and Morrell (2013) and Boardman et al. (2003) defined work as an activity that produces something, whether it is a service or a product, which is then rewarded monetarily. Work being defined narrowly as ‘paid employment’ has meant that groups of people are consistently socially excluded, and Barnes (2000) and Barnes and Mercer (2005) argued that waged labour ensures a systemic exclusion of individuals with disabilities. Barnes (2000) argued that in order for work to be an inclusive space for individuals with disability, the concept and meaning of work needed to be radically transformed, specifically constructed with an understanding of social model of disability and how it relates to work. Similarly, Barnes and Mercer (2005) argued that research and discussion concerning the relationship between work and disability have failed to adequately examine the social and environmental barriers faced by individuals with disability. Soldatic and Chapman (2010) similarly argued that work has been constructed around an ideal worker who is male and able-bodied.

Work is idealised within political discourse and the literature as a solution to many social issues, and, as Patrick (2012) observed, work is prescribed to society as the means to success,

prosperity, and well-being, whereas unemployment is often vilified and seen as a source of social ills. While the literature does highlight the importance and social value of work, particularly in relation to health and well-being, Broom et al. (2006) and Connor (2010) highlighted that paid work secures resources for individuals in the most fundamental way; it enables people to be able to access the necessities of life including affordable, adequate housing, nutrition, and also goods and services that enhance their enjoyment of life. Pilgrim (2017). Villotti, Corbiere, Zaniboni, and Fraccaroli (2012) also discussed how work contributes to other benefits including a sense of achievement, life satisfaction, and social connections. Ford et al.'s (2010) quantitative research within the UK found that individuals who were unemployed had a higher rate of common mental disorders, illustrating how work is critical to mental health. Work is described as beneficial in terms of monetary security but primarily through delivering social benefits which are seen to positively impact mental health. The impact of employment on health is well established in the literature, for example, Marmot (2006) described health on a social gradient where individuals with greater social status, which is generally a reflection of income and access to resources, typically have better health. In their studies, Bartley (2006) and Ford et al. (2010) observed a decline in mental health when participants lost their job and an improvement in mental health when participants were reemployed. As highlighted by Dominy and Hayward-Butcher (2012), who surveyed 96 users of mental health services in the UK, many individuals with mental illness would like to work, and findings suggest that quality of life improves for individuals once they are employed. However, the emphasis on work is also critiqued in the literature, being seen as part a neoliberal discourse, characterised consistently in the literature and in policy as the way to escape poverty and ensure success, often without acknowledging inequalities within the working populations and the discrimination of the labour market (Carpenter, Freda, & Speeden, 2007; Patrick, 2012).

3.4.2: Discrimination and Stigma in the Workplace

While work is discussed in the literature as a positive experience for individuals with mental illness, the literature on mental illness and employment also focuses on the concept of stigma; it is a prevalent topic within mental illness research. Stigma, as defined by Hampson, Watt, Hicks, Bode, and Hampson (2018) and Krupa et al. (2009), is a concept based around the intolerance of behaviours, thinking, or practices that are seen as non-normal or different.

Stigma is associated with how individuals with mental illness are negatively perceived by others, often following narrow stereotypes, as well as how they negatively perceive themselves, which is defined as self-stigma (Rüsch, Angermeyer, & Corrigan, 2005). According to Krupa et al. (2009), discrimination is the action of stigma. For example, while stigmatising attitudes and beliefs might be held by colleagues and employers, discrimination is enacted through workplace policies and lack of accommodations that mean individuals with mental illness are unable to easily access employment. The literature, including reports on research, overall tends to focus on stigma in relation to mental illness rather than discrimination, this is perhaps because one is seen to lead to the other, and maybe also because stigma examines individuals' attitudes and beliefs whereas discrimination research and other literature would need to examine collective realities and systems.

Societal discourse surrounding mental illness frequently reinforces stigma through the media, policy, and non-competitive work programmes (Krupa et al., 2009). The discourse of mental illness, as observed by Elraz (2018), can create subject positions for individuals with mental illness that are oppressive and limiting; managing stigma and discrimination therefore becomes a significant part of an individual's management of their mental illness, and can be a significant barrier in accessing employment. Arboleda-Flórez and Stuart (2012) and Hampson et al. (2018) noted that an unfortunate impact of the medical discourse of mental illness was that it gives the impression of an incurable, genetic illness, which has been seen to increase society's stigma towards mental illness. In some studies, it has been found that stigma has increased in recent years; in 1996 and again in 2006, Schnittker (2008) conducted a general social survey to explore trends in public beliefs around mental illness, and found that alongside a rise in a biomedical understanding of mental illness in the US, there was an increase in stigma. This rise in stigma was thought to be partially caused by increased public understanding that there can be genetic or chemical causes for mental illness coupled with a belief that mental illness due to such causes cannot be cured and is inherent within some people (Schnittker, 2008).

Ways of combating stigma is also a key focus in the literature, with education and familiarity with mental illness being understood to be the primary ways of shifting social attitudes surrounding mental illness (Arvaniti et al., 2009; Hampson et al., 2018). Arboleda-Flórez and Stuart (2012) discussed a broad overview of stigma literature and found there were six common approaches highlighted to reduce stigma: education, protest, contact-based education, legislative reform, advocacy, and self-stigma management. Education

programmes, particularly ones that capture the voices and experiences of individuals with mental illness, have been observed to be a key way of shifting social attitudes and understanding towards mental illness (Arvaniti et al., 2009). Krupa et al. (2009) additionally argued that employment of individuals with mental illness can be a way to reduce stigma, by providing an opportunity for individuals with mental illness to participate in society, be included, and simultaneously combat negative stereotypes that may be present in the workplace. Unfortunately, due to discrimination being embedded within workplace systems, utilising work as a way to try to reduce stigma is challenging.

As already stated, Krupa et al. (2009) defined discrimination as the act of stigma—the tangible performance of stigma—therefore discrimination in the workplace towards individuals with mental illness was the particular focus and interest for their research. As Baumann (2007) noted, discrimination in the workplace generally means that the abilities and competencies of individuals with a mental illness are underestimated at work. Elraz (2018) highlights how individuals with mental illness are consistently offered only low-status work due to the perception of their lack of abilities to manage heavy workloads or high stress environments. Krupa et al. (2009) additionally highlighted that discrimination in the workplace also often resulted in lower wages for individuals with mental illness, a lack of opportunities for promotion, and frequently challenging relationships with colleagues and employers. Discrimination also contributes significantly, and perhaps most consistently, to the lack of employment opportunities and the experience of unemployment of individuals with mental illness (Elraz, 2018; Hampson et al., 2018).

3.4.3: Disclosure: Revealing Invisible Social Identities

In order to avoid being discriminated against in the workplace, individuals with mental illness often choose to not disclose their mental illness (Clair et al., 2005; Elraz, 2018; Krupa et al., 2009). The literature reveals various tensions surrounding disclosure with regards to mental illness, particularly highlighting that, as mental illness is invisible compared with other forms of disability, it is often an individual's choice to reveal their non-normal experience or attempt to pass as normal (Clair et al., 2005; Corrigan & Matthews, 2003).

A question that arose in the literature, concerned factors that limited or encouraged disclosure of mental illness. In research conducted in Canada by Krupa et al. (2009), fear of stigma and discrimination were identified as factors that limited disclosure. Similarly, in New Zealand

based research by Peterson (2007) and Dew et al. (2007), fear of discrimination or negative consequences were discussed as reasons for not disclosing mental illness. Ragins (2008) noted that individuals felt encouraged to disclose if the risks of disclosure were outweighed by self-identified positives impacts, for example the positive impact of being authentic and not having to hide a stigmatised identity.

Corrigan and Matthews (2003) examined the disclosure processes and literature around sexual identity and suggested that it could provide insight for individuals with mental illness as well. The sexual identity disclosure literature examined by Corrigan and Matthews (2003) identified several stages within the process of identity and disclosure: identity confusion, comparison, identity acceptance, immersion, and identity synthesis. Each stage resulted in different engagement with disclosure as well as understandings of self (Corrigan & Matthews, 2003). Ragins (2008) similarly observed that the choice to disclose often revolves around how the individual identifies with the idea of having a mental illness and also the risks they are managing within whichever context, whether social risks or the risk of unemployment.

Individuals can also choose to adapt, accept, or reject social identifiers placed on them, and as Jammaers et al. (2016) highlighted, individuals with mental illness negotiate and construct their own identities based on the various discourses surrounding them; disclosure may not seem necessary for some individuals who do not see their mental illness as a part of their self-concept or even see themselves as having a mental illness (Jammaers et al., 2016; Ragins, 2008).

3.4.4: The Effect and Discourse of Unemployment

While work is placed on a pedestal within society, within dominant discourse unemployment is cast as a social affliction; the number of individuals with mental illness who are unemployed is a global concern reflected in the literature. International research and policy consistently refers to the ‘economic burden of mental illness’, referring to the financial costs of mental illness when an individual is unemployed or partially employed (Harder et al., 2016; OECD, 2012). Harder et al. (2016) highlighted how individuals with mental illness are more likely to be unemployed than individuals without mental illness. Boardman et al. (2003) noted that individuals with mental illness are not likely to find or maintain ‘open employment’ but rather need supported employment opportunities. Dominy and Hayward-

Butcher (2012) discussed the growing numbers of individuals with mental health issues taking sick leave or claiming health and disability benefits in the UK. Globally, concern about the lack of employment for individuals with mental health is prevalent both in international policy and research and also in recovery literature.

While the literature indicates that discrimination and stigma are contributing to a lack of access to employment for individuals with mental illness, there are other barriers, including medication side effects and mental illness interrupting critical times in education and gaining employment experience. Bond and Meyer (1999) and Southern and Miller (2012) both highlighted the role of medications impeding the ability of individuals with mental illness to perform well in the workplace, particularly with the common side effect of lethargy.

Participants in Southern and Miller's (2012) research claimed that while remaining compliant with their medications was important, they often struggled with the side-effects. Bond and Meyer (1999) noted a general lack of understanding from professionals regarding the negative social consequences of medication's side effects, where medication compliance is seen as essential and non-negotiable. The impact of medication alongside the onset timing of mental illness can mean an individual's employment career is disrupted. Shankar, Barlow, and Khalema (2011) noted that individuals with mental illness often have an early onset in their late teen and early twenties, resulting in an interruption to both education and employment opportunities and experience. While there are systemic reasons and practical reasons why individuals with mental illness struggle within employment as highlighted above; frequently in terms of policy and media discourse, unemployment is seen as an individual's problem, and seen as the result of poor individual choices and behaviours (Patrick, 2012).

The abhorrence of unemployment is reflected within policy, broader public discourse, and the media. In Garthwaite's (2011, pp. 370-371) research, common rhetoric surrounding the media portrayals of unemployed individuals featured labels such as: "scroungers" and "cheats", and being unemployed and on a government benefit was termed a "lifestyle choice" or being part of a "culture of worklessness". Beddoe (2014, p. 51) examined New Zealand media items that featured words such as "ferals" or "underclass" of which she found 721 instances between 2006-2012; these words were often linked to unemployment, representing a pattern of vilifying unemployed and lower socioeconomic families in New Zealand.

Wiggan (2012) and Lantz and Marston (2012) illustrated the degraded moral status of unemployment, reflected in the relentless idea frequently seen in the media and in policy that

individuals are unemployed through poor decisions and behaviours. Patrick (2012) and Beddoe (2014) noted that the unemployed subjects, who are challenging the normative discourse of a neoliberal, economic subject, are consistently portrayed as problematic, immoral, and irresponsible individuals. There is also a persistent idea of a lack of motivation within unemployment rhetoric as discussed by Patrick (2012) and Lantz and Marston (2012). The individual faults and failure highlighted in the media surrounding unemployment, Fejes (2010) and Beddoe (2014) argued, distract from the systemic causes of unemployment.

Unemployment is also discussed in the literature as having negative impacts on mental health. Unemployment and job loss are two life experiences that are classified in the literature as significant stressors that cause mental distress that can in turn lead to mental illness (Patrick, 2012; Shaw, 2006). Ford et al. (2010) and Shaw (2006) highlighted the financial strain associated with unemployment, which would limit the material circumstances of individuals. Shaw (2006) additionally noted that unemployment often resulted in poor housing, poor nutrition, and limited resources and choices. Bartley (2006) and Ford et al. (2010) also highlighted the social losses associated with unemployment particularly loss of social status and esteem but also loss of social connections and social inclusion. The impact of unemployment on economic and social circumstances can result in long-term health consequences (Shaw, 2006). Workfare policy, Patrick (2012), noted can be seen as an attempt to negate the negative health consequences of unemployment. However, the literature does critique the issue of negative perceptions of unemployment and the push to employment, noting that the type of work also plays a critical role in the health and economic benefits, which is explored further in a later section of this chapter.

3.4.5: Welfare Reform, State Discourses and Pressures

As noted previously, recent welfare reform in New Zealand and other democratic western governments has placed additional importance on and expectations around work (Gibson, 2009; O'Brien, 2013). Humpage (2007) and Soldatic and Pini (2009) observed that reforms from a welfare state to a workfare state have been made in the US, Canada, UK, Australia, and New Zealand. Literature examining the changing policies of governments is generally critical of the shifts from welfare states to workfare states, arguing that this change further vilifies poverty, framing unemployment as a moral issue, a character flaw, and an

individual's responsibility rather than acknowledging any structural or systemic causes (Beddoe, 2014; Gibson, 2009).

The discourse surrounding the shift to workfare policy by numerous governments relies on a shift in understanding around previous welfare policy. Governments have reinforced that welfare in its previous form was inefficient and created dependency rather than helping people to help themselves (Garthwaite, 2011; O'Brien, 2013). O'Brien (2013) explored the changing perspectives surrounding welfare provision in New Zealand, noting that the neoliberal ideology had placed a greater emphasis on the individual responsibilities of beneficiaries, at the expense of citizen rights. Bambra and Smith (2010) similarly discussed the changes to welfare provision in the UK, examining particularly the impact on individuals with an illness or disability and the conditionality around 'active' welfare provision that requires individuals to act in particular ways in order to receive support. The discourse surrounding the workfare policy, Bambra and Smith (2010) observed, maintains that the reforms to welfare policy are 'empowering' and 'inclusive', and that this is policy designed to effectively get people out of unemployment and into work rather than create dependency. Lunt (2006) observed a shift in public perception, led by the government and media, regarding the move from passive welfare without conditions, which is now framed as ineffective, to active welfare, or workfare policy with conditions, which is perceived and implied to be more effective. Beddoe (2014) argued that this shift in language and attitude to welfare has meant that welfare reform has been able to take a strong conditional and punitive approach to welfare recipients, ensuring individuals do not remain unemployed but are 'activated' and often coerced into employment.

The changes in welfare discourse and policy in New Zealand and elsewhere have had a strong impact on individual welfare recipients, particularly those with disabilities (Lantz & Marston, 2012). Lantz and Marston (2012) and Humpage (2007) observed that there has been a move to increasing frequency of assessments of sickness and disability recipients. Similarly, Bambra and Smith (2010) noted an increased pressure on individuals with impairments or illness to adequately prove and justify their needs, while also ensuring that they are being 'activated' and equipped to work as much as their impairments allow. Garthwaite (2011) argued that there is evidence of an increasingly negative attitude and attack on the deemed 'undeserving' recipients of benefits, and a belief that individuals are using the label of 'disability' or 'sickness' as a way of avoiding their responsibility as citizens to work. Beddoe (2014) claimed that the welfare changes to a work-centric approach have

constructed individuals on the benefit, regardless of their circumstances, as dysfunctional, irresponsible, and undeserving of care, unless they find work or make efforts to find work. This view again highlights the social importance and significance given to paid work and, as Barnes (2000) and Howard et al. (2018) noted, does not address the systemic and social issues contributing to the employment barriers and experiences of individuals with disabilities or mental illness. This is particularly unhelpful, as Humpage (2007) pointed out, since many individuals with disabilities and mental illness would like to be working and not have to receive support from the state.

An assumption inherent within workfare policy is that supporting the unemployed into work will improve health, and will relieve poverty. The reality is unfortunately more complicated, as highlighted in the literature. A number of authors have pointed to the danger in the rise of insecure and low-quality employment. Pilgrim (2017) and Bartley (2006) both highlighted the relationship shown in research between insecure, low-paid work and poor mental health outcomes. Lunt (2006) and Barnes (2000) highlighted that while workfare policy may be assisting individuals to find employment faster, it does not guarantee the quality of the work found. Barnes (2000) and Bambra and Smith (2010) argued that the employment opportunities found, particularly for individuals with a disability, reflect low-status, low paid, and often insecure work. Patrick (2012) additionally observed that work is not in fact a sure way out of poverty, particularly with the rise in insecure jobs, despite the emphasis of workfare policy. While unemployment is associated with poor mental health outcomes, as Broom et al. (2006) posited, some employment experiences are worse for an individual's mental health than not having a job. Precarious, low-quality work, Shankar et al. (2011) noted, often contributes the same health risks as unemployment because it causes additional mental distress while not providing enough income to ensure an individual escapes poverty.

3.4.6: Critiquing Individual Employability and the Labour Market

The concept of employability supports and is reinforced by workfare policies and neoliberal discourse. Garsten and Jacobsson (2013) discussed the normative category of the 'employable individual', or as discussed previously in this chapter, the 'ideal worker'; the person who is seen as most attractive by the labour market. However, what happens to individuals who do not meet the market expectations? The concept of employability developed in the UK in the late 1990s and has since been adopted by other countries

including New Zealand as a rhetoric to combat unemployment (Lunt, 2006). Lunt (2006) explored the employability discourse within New Zealand, framed within welfare initiatives that seek to target the employment outcomes of specific groups, including individuals with disabilities. Fejes (2010) examined employability in a European setting, using Foucauldian discourse analysis to examine policy documents on life-long learning and the labour market. Fejes (2010) noted that employability was developed as a way for governments to ensure that the labour market remained productive and performing well by encouraging individuals to continue to develop their competencies.

The individualistic focus of the rhetoric of employability is one of the strongest critiques within the literature. Garsten and Jacobsson (2013) pointed out that according to this rhetoric, individuals are responsible for making themselves more attractive to the labour market, therefore ensuring they do not remain unemployed. Elraz (2013) observed that the pressure on individuals to make themselves attractive to the labour market means that individuals are less able to openly discuss their weaknesses or illness in the workplace, which is of particular concern for individuals with a disability or mental illness. Garsten and Jacobsson (2013) emphasised that there are in fact some individuals in society, particularly those with disability and mental illness that may never be able to make themselves desirable to the open labour market. Employability in policy has shifted the issue of unemployment on to the individual's lack of flexibility, market competitiveness, and desirable competencies.

The critique of employability in the literature also highlights the flawed thinking behind policies that seek to address unemployment only from an individual perspective while neglecting to institute any regulation of the larger market system. Peck and Theodore (2000) observed that the cause of unemployment is assumed to be individual behaviour rather than, as Fejes (2010) argued, problems within the labour market. Lunt (2006) additionally noted that while employability policy encourages individuals to develop skills, its limited focus on the supply side of the labour market ensures that the government avoids responsibility for unemployment, and individuals are therefore further susceptible to the societal stigma associated with unemployment. As highlighted in the literature, constructing unemployment as an individual problem, or individualising the experience of unemployment, makes it difficult for groups of people who are discriminated against in the workplace to challenge the systems that exclude them.

3.5: Conclusion

This review examined research literature discussing mental illness, economic systems, and work, and broadly examined how the literature considers that the experience of mental illness interacts with economic realities for individuals with mental illness. As highlighted in the literature, there are various ways to construct and understand the experience of mental illness. For example, some researchers discussed mental illness through a medical or health discourse, whereas others examined the social and contextual experience of mental illness, for example, how poverty or unemployment impacts mental illness. Despite the different discourses constructing different understandings and meanings, mental illness is still frequently constructed as a ‘non-normal’ identity that needs to be managed, treated, or in the case of disability discourse, accommodated.

Of all the discourses in the examined literature, only the literature on disability discourse offers a clear critique of social, political, and environmental structures that discriminate against the stigmatised identity of mental illness. Disability literature and research highlights how disability discourse, particularly the social model of disability, can offer a way to challenge ableist social systems. This is significant, especially in relation to workplaces and access to employment. Access to employment and having work was discussed in the literature as being critical to mental health, however, discrimination towards individuals with disabilities, such as mental illness, means that employment is not easily obtained.

The research and literature on work and economic systems highlights how work-centric discourse is embedded within social understandings and social systems, apparent in recent changes to welfare structures, as well as in the emphasis on employment as a means of supporting mental health. However, as noted in the literature on unemployment, the individual is generally constructed as the problem, not the discriminatory labour market. In order to avoid discrimination and the risk of unemployment, researchers found that many individuals would not disclose their mental illness. Remaining a hidden, stigmatised identity would mean that individuals would be perceived by employers as more employable, as a ‘good worker’ rather than a ‘non-normal’ or ‘unproductive’ worker.

The experience of unemployment is frequently considered to be an individual problem, although this perception is heavily critiqued in the literature. In a similar way, the experience of mental illness is constructed as an individual experience, although this is less noticeably critiqued within the literature, with the exception of literature reflecting disability discourse.

Within this research project, I built on the existing research literature by examining the impact of discourse on the experiences of individuals with mental illness, particularly in the workplace. I examined the discourse and constructions of mental illness, alongside particular work discourse and economic discourse embedded within society, and looked at how these impacted individuals with mental illness. How mental illness is constructed, and the expectations and understandings of work, impact the lives and subject identities of individuals with mental illness. I paid particular attention to systems and broader social constructions and my thesis is therefore critical of social experiences such as unemployment and mental illness being seen as an individual problem to be managed.

CHAPTER FOUR: METHODOLOGY

4.1: Introduction

My concern over my good friend, who struggled to make his way through mental health services and also into economic structures and support, provided the starting point for my research. When my friend was finally hospitalised, I spent considerable time and energy trying to grasp his situation and understand what was happening to him. This involved many trips to the library where I immersed myself in mental illness autobiographies, self-help-type books, and some well researched histories of mental illness. However, despite the relief at finding stories relevant to my friend's experience, I was unsatisfied. I did not see enough of the larger, systemic story, specifically an economic story, that I felt contributed to my friend's illness. From my perspective, the primary hardship my friend experienced as a result of his mental illness was economic. He struggled to work, he had long periods of unemployment resulting in large debts, and his work opportunities were frequently inconsistent, under paid, and often featured a low level barrage of mistreatment. I cannot conceive of my friend's illness outside of his economic reality and the economic reality we all live within. In my research, I wanted to examine the structural, systemic and social responses to individuals with mental illness that are taken for granted and Foucault seemed to offer a way to do that.

There are a number of ways I could have approached this research project but, after some deliberation, Foucauldian discourse analysis seemed to offer the best fit. Other research examining mental illness and employment used narrative analysis such as the research by Southern and Miller (2012), or ethnography, such as the research conducted by Moll, Eakin, Franche, and Strike (2013) and Fletcher (2018). A New Zealand based research study on disclosure by Peterson (2007) took a qualitative approach using mixed methods, featuring a semi-structured questionnaire and structured interviews. The research examining positive experiences of open employment by Gordon and Peterson (2015) used a case study approach. However, these alternative methodologies would not have provided me the same opportunity to examine systemic aspects of mental illness and employment, and I was drawn to Foucault as he himself examined the social construction of mental illness within *The History of Madness* (Foucault & Khalfa, 2009)

In his research, Foucault (1965) examined the evolving discourse of mental illness through historical documents, both within literature and non-fiction documents, and through

observation of common social practices towards individuals with mental illness. Foucault (1965) also examined the subject identities and power dynamics present between doctors and patients—individuals who were deemed to have authority to correct ‘non-normal’ behaviours and thinking and individuals positioned to receive correction or simply be confined away from rational society. Alongside this, several recent research projects further inspired my choice of methodology, particularly the discourse analyses conducted by Ringer and Holen (2016) and Elraz (2018), both of which examined the construction and discourse of mental illness, with Elraz (2018) looking at this within the context of work.

Foucault, in an interview, stated that “the real political task in a society such as ours is to criticise the working of institutions which appear to be both neutral and independent” (Rabinow, 1984, p. 6). The institutions that appear to be neutral in the case of my research, and the experience of my friend, are the economic structures and mental health structures that intersect within the workplace and impact the experience of all individuals with a mental illness. A Foucauldian methodological approach was a natural fit both for the subject matter of mental illness and also for my own personal interest in structural and systemic influences on society, particularly the economic systems and realities impacting the experiences of individuals with mental illness. As Garrity (2010) and Hook (2001) noted, Foucault provides a methodology to question assumptions about society and our social reality. The reality that I witnessed my friend facing was, in my view, part of a broader social problem, however, I observed this was not how he experienced it or how most people saw it. He was seen to be having health issues and this was understood as an individual problem to be managed. Foucault offers researchers a way to critique society and the social constructions that are dominant and frequently unquestioned.

A Foucauldian approach to social research emphasises the understanding that ‘truth’ is a construction, and that the aim of Foucauldian discourse analysis is not to reveal the truth but rather to understand what are the social conditions that mean that these particular ‘truths’ or discourses are legitimised or opposed by sections of society (Graham, 2011; Hook, 2001). Power produces truths or discourses, it also produces subjects: subjective identities and rules of control that individuals are subject to (Roberts, 2005; Stevenson & Cutcliffe, 2006). As Roberts (2005) noted, Foucault focussed on how authority, discipline, and surveillance were used by institutions to make individuals subject to particular social and moral controls. Many of these techniques of government can be seen in both the economic structures and mental

health structures, guiding individuals to behave, speak, and live in particular ways emphasised by normative discourse or accepted ‘truths’ (Elraz, 2018; Fejes, 2010).

This chapter will discuss my methodological approach, the choices I made, and struggles I encountered. While I chose to use Foucauldian discourse analysis as my methodology, the experience of the research process and application of Foucauldian discourse analysis was not always clear or easy. Foucauldian discourse analysis has provided me as a researcher with a range of theoretical tools and ideas to examine and apply to my research, however, figuring out which aspects of Foucault’s theoretical concepts would be best suited to my research purpose has been difficult and relied on a slow untangling of complex ideas, helped by other academic studies using and discussing Foucault. In this chapter, I highlight the key ideas and concepts from Foucault I have used in my analysis, and discuss my evolving understanding of discourse and discourse analysis broadly.

4.2: Discourse Analysis and Foucault

As discussed in the introduction chapter, discourse as a concept has a variety of meanings and understandings attached to it, depending on the discipline and the research area (Garrity, 2010). While Foucault focused on discourse as it relates to structural processes (Garrity, 2010), other researchers have examined discourse through text and talk, looking at use of language and the construction and process of meaning-making (Ainsworth & Hardy, 2009). Discourse analysis is the research approach involved in mapping, analysing, and interpreting discourse present within documents, interviews. Within Foucauldian discourse analysis this includes an examination of social practices, symbols, and signs (Starks & Trinidad, 2007; Traynor, 2006). Ainsworth and Hardy (2004) discussed two distinct forms of discourse analysis: descriptive studies and critical studies. Ainsworth and Hardy (2004) defined descriptive studies as discourse studies that primarily focus on language, whereas they defined critical studies as the examination of discourse within broader contexts, for example, political and economic contexts. Foucauldian discourse analysis and critical discourse analysis both sit within critical studies of discourse (Ainsworth & Hardy, 2004).

In order to understand what was meant by Foucault as the methodological approach of discourse analysis, it is necessary to explore how Foucault described ‘discourse’. As already noted, discourse was categorised by Foucault as patterns of language, symbols, and signs that are related to social practices (Traynor, 2006). Additionally, according to Foucault, discourse

influences the way in which certain thoughts and social behaviours are possible; discourse limits and empowers specific social behaviours and ideas (Hook, 2001; Nicholls, 2009). While Foucault stated what role discourses play in society, he did not seek to define a particular discourse but rather suggested that discourse or discursive formations can be mapped through observing and analysing the social practices, strategies, concepts, and relationships to other discourses, whether complementary or oppositional (Nicholls, 2009). In the case of this research, the discourse of mental illness, economic discourse, and work discourse will be examined and mapped through common social practices and strategies and through subject positions. While Foucauldian discourse analysis was a clear choice for my research, its application was not without difficulty or concerns.

4.3: Concerns with Foucauldian Discourse Analysis

While I chose to use Foucauldian discourse analysis as my methodology, I was aware and cautious of two main concerns associated with Foucauldian discourse analysis, namely Foucault's fatalistic emphasis on discourse as occurring beyond an individual's free will, and the lack of clarity in his writing about how to apply discourse analysis. Foucauldian discourse analysis is critiqued as being too deterministic (Ainsworth & Hardy, 2004). According to Ainsworth and Hardy (2004), Foucault framed discourse as pervasive and a determinant of everything, not allowing for individuals possessing free will to determine their own engagement with, and roles in, society. Foucauldian approaches to discourse are accused of discounting an individual's ability to navigate and interpret discourse. Instead, the subject positions that an individual holds are seen as being produced by discourse, and therefore discourse is understood to shape identity, beliefs, and action (Ainsworth & Hardy, 2004). While Foucault's perception of the operation of discourse appeared fatalistic, his later work emphasised freedom and agency of the self through self-governance in everyday living and so in part this contradicts the deterministic role of discourse (Richmond, 2010). Additionally, as Elraz (2018) noted, Foucault's concept of discourse still provides a way to understand how identities are constructed and individuals may hold multiple subject identities which contribute to different ways of engaging with society.

Alongside the critique that Foucauldian discourse analysis is too deterministic, the concern over how to apply a Foucauldian discourse analysis was highlighted by several researchers including Hook (2005) and Garrity (2010). Hook (2005) argued that Foucauldian discourse

analysis in fact does not exist as a form of discourse analysis because a researcher employing discourse analysis is required to be specific and Foucault described no specific method or steps for analysing discourse. Instead Foucault discussed numerous concepts and left the researcher to apply these to their research (Garrity, 2010; Graham, 2011; Hook, 2005). To deal with this critique, it is important for a researcher to be specific in how they themselves have defined the concepts introduced by Foucault, and explicate how they have applied these concepts in their research, especially given the changing and evolving nature of Foucault's lifetime body of work (Garland, 2014).

4.4: Foucauldian Approach to Research: Theoretical Concepts

The difficulty with choosing to follow a Foucauldian methodological framework, as already stated, is that there are no set procedures or methods outlined by Foucault. Foucault provided a theoretical base, but it is less clear how to practically undertake his approach to discourse analysis (Garrity, 2010; Nicholls, 2009; Stevenson & Cutcliffe, 2006). However, there are two main ideological approaches within Foucauldian inspired methodology: the archaeological approach and the genealogical approach, which offer some process as to how to undertake a Foucauldian discourse analysis (Dreyfus & Rabinow, 1982; Garrity, 2010; Graham, 2011). The archaeological approach, genealogical approach, and other key concepts of Foucault are discussed in more depth in this section.

4.4.1: Archaeology

Discourse was the primary focus of Foucault's archaeological approach to discourse analysis, whereas, Garrity (2010) noted that in Foucault's later work in genealogy, discourse was still relevant, but the focus was more on power and power relations. The archaeological approach to discourse analysis was the methodology of Foucault's earlier work which focussed on discourse and providing a descriptive picture of a social phenomenon, for example mental illness (Garrity, 2010; Stevenson & Cutcliffe, 2006). The key task of an archaeological approach to discourse analysis is to analyse "why a certain statement emerged at the exclusion of others" and the function that the statement serves (Graham, 2011, p. 667).

In *The Archaeology of Knowledge*, Foucault described statements as the basic unit or atom of discourse (Foucault, 1969). Foucault noted that a statement is not necessarily the same as a

sentence or phrase but can also be a list, a visual sign, signal, or graph (Foucault, 1969; Garrity, 2010). According to Foucault (1969), the defining feature of a statement is that it is a function. Graham (2011) and Garrity (2010) further explained that this function facilitates groups of signs and rules to exist and link to other statements within the discursive formation or enunciative field. Statements, according to Foucault (1969) are always making reference to something else; a statement is never independent or neutral but is constructing itself in relation to other statements within the enunciative field or discursive formation. The enunciative field is a network, or context of a statement, which links statements to other statements within discourse (Foucault, 1969). The purpose of a statement is to make visible objects, subject positions, concepts, and strategies, which are the main components in the analysis of statements based on an archaeological approach to discourse analysis (Foucault, 1969; Nicholls, 2009).

In following an archaeological approach to discourse analysis, Foucault (1969) stressed that statement analysis is non-interpretive, the focus is on the description of what is in the statement rather than searching for hidden meaning or for what remains unsaid (Garrity, 2010; Kendall & Wickham, 1999). The statement is taken at face value and the source of the statement, the subject, is not used to source any further meaning (Garrity, 2010). Instead, the subject is seen as a product of discourse and therefore their personal influence on the statement is not a factor (Garrity, 2010).

4.4.2: Genealogy and Power

Foucault's earlier ideas from archaeology were later focused into what he termed the genealogical approach, a methodology primarily concerned with the analysis of power and the relationship between power and knowledge (Garrity, 2010; Stevenson & Cutcliffe, 2006). While some scholars and researchers, including Garrity (2010), have discussed a strong distinction between archaeology and genealogy, others including Stevenson and Cutcliffe (2006) have highlighted the overlapping ideas and concepts present in both methodological approaches. For example, the concepts of discourse and power and an emphasis on subject identity and power dynamics within relationships and interactions are present in both methodological approaches. Despite archaeology and genealogy being described as distinctive and different approaches to research, Foucault himself stated in an interview that

he never stopped doing archaeology; archaeology was a necessary part of his work on genealogies (Mahon, 1992, cited in Tamboukou, 1999).

While Foucault's genealogical approach built on archaeology, within genealogy, as previously noted, power becomes a particular focus of the analysis. However, Foucault's conception of power evolved and took different forms throughout his career (Garland, 2014). Foucault discussed power as a productive force that produces subjects, subject positions, and particular discourses or 'truths' (Garland, 2014). Foucault was interested in the relationship between power and discourse (truth/knowledge), and understood that power could not be established without the production of particular discourses (Nola, 1998). In this way, power and discourse are intrinsically related, some discourses are more dominant than others or carry greater authority while other discourses resist, challenge, or adapt the pervasive, dominant discursive formations embedded within social structures.

In the same way, Foucault stated that dominant forces and discourses can also produce subjective identities, which individuals accept, adapt, or resist. These subject identities or discursive formations, and how individuals respond to the discursive formations, construct who they are and their understandings of how they should behave (Roberts, 2005). While power is acting through discourse and producing further discursive formations and subject identities, power is always relational and there is always resistance and tension against particular discursive formations (Stevenson & Cutcliffe, 2006). The role of the analyst within genealogy, is to assess the power relations within a particular social phenomenon, exposing the role of power in producing a particular 'truth' that society comes to accept, while also highlighting the resistant or alternative discourses that are present but currently not seen as the accepted knowledge or truth in the world (Dreyfus & Rabinow, 1982; Stevenson & Cutcliffe, 2006; Tamboukou, 1999).

4.5: Foucauldian Discourse Analysis in Practice

As already noted, it is important for a researcher to be specific in defining concepts and in the application of Foucault's concepts given the changing and evolving nature of his work (Garland, 2014). While some researchers and academics such as Garrity (2010) have favoured an archaeological approach to Foucauldian discourse analysis, others such as Garland (2014) and Tamboukou (1999) suggested that a genealogical approach is preferable, and researchers such as Stevenson and Cutcliffe (2006) have suggested that there is no great

distinction between an archaeological approach to Foucauldian discourse analysis and a genealogical one, but rather they exist on a continuum.

Within the Foucauldian discourse analysis research reviewed, most researchers did not state specifically whether they were using an archaeological or a genealogical approach. For example, the media study conducted by Rowe, Tilbury, Rapley, and O'Ferrall (2003), which used discourse analysis and discussed Foucault, did not explicitly explain the authors' understanding of discourse or how they used Foucault's concepts within their research. Similarly, although explained in greater depth, the discourse analysis conducted by Ringer and Holen (2016) appeared to be drawn from an archaeological understanding of discourse as they explained discourse as social practices and signs that form subject identities and objects, and made no mention of the role of power. However, within the findings and discussion, power was explored, specifically the power dynamic between the subject identities of service users and mental health professionals (Ringer & Holen, 2016). Therefore, in both cases the practice of Foucauldian discourse analysis remained unclear, and instead these researchers appeared to draw on Foucault in a broader sense, particularly focusing on Foucault's concept of discourse.

Other researchers have focussed on different elements and concepts developed by Foucault, for example, in the discourse analysis by Jammaers et al. (2016) and by Elraz (2018), power was a larger focus, suggesting a more genealogical approach. Jammaers et al. (2016) highlighted and critiqued Foucault's concept of disciplinary power within their research. They noted that while disciplinary powers might produce normative discourse, specifically an ableist discourse, this did not always have a negative impact on the subject identities of 'non-normal' individuals with disabilities within their research (Jammaers et al., 2016). Instead, Jammaers et al. (2016) argued that identity formation consists of multiple subject positions, and often individual subject identities that are seen as 'non-normal' and outside of the normative discourse produced by disciplinary powers, will resist this discourse in order to hold on to a positive subject identity. Elraz (2018) similarly discussed Foucault's concept of power as it relates to subject identity, however, instead of disciplinary power, he discussed how the relationship between power and knowledge produces particular subject identities, specifically in the workplace where knowledge and discourse grants subject identities particular power or authority. While the research by Jammaers et al. (2016) and Elraz (2018) both discussed and drew on Foucault's concept of power and subject identity, they interpreted

the concept of power differently and this illustrates how broadly Foucault can be applied to discourse analysis.

Foucauldian discourse analysis is a term with broad application, as noted within the Foucauldian discourse analysis research examined, however, there are some common ideas. One fundamental aspect of a Foucault-inspired approach to social research is the understanding that ‘truth’ is a construction, and that the aim of discourse analysis is not to reveal the truth but rather to understand what are the social conditions that mean that this ‘truth’ is legitimised or opposed by parts of society (Graham, 2011; Hook, 2001). Garrity (2010) also noted that a key aspect of a Foucauldian methodology, particularly an archaeological approach, is that the focus is not on discovering a unified and coherent theory through the research process, but on revealing diversities, complexities, and oppositions within the discourses acting on the subject matter. Kendall and Wickham (1999) highlighted that when using Foucault, researchers are encouraged to turn “uncertainty into a virtue” (p. 22) and not look for a universal, singular truth but rather to use discourse analysis to map the edges, incongruities, relationships, and opposing forces of a social phenomenon. As a researcher using Foucauldian discourse analysis, I had to grapple with uncertainty and try to unravel and apply ideas of Foucault to my own research process.

4.5.1: Interpreting and Applying Foucault

My methodological approach has been influenced by both Foucault’s archaeological approach and his genealogical approach. In my use of Foucauldian discourse analysis, I focussed on the analysis of statements used to map a social phenomenon, as well as the understanding of how power is functioning and producing a discourse or particular ‘truth’, and also how power impacts the dynamic relationships between different subject identities. Initially, I favoured an archaeological approach to discourse analysis, as I found the details of the methodological approach within *The Archaeology of Knowledge* by Foucault (1969) easier to follow because Foucault outlined specific ways to analyse statements, whereas Foucault’s changing conception of power was more confusing to grapple with (Garland, 2014). However, I realised I could not ignore Foucault’s later focus on power and dynamics of power between subject identities and between discursive strategies. I realised that it was critical to my research to observe which discursive constructions were more dominant in particular settings. An analysis of power is important to my research project as it reveals the

dominant and hegemonic discourse that power is producing and it also highlights how dominant discourse impacts subject identities. My analysis therefore ended up drawing on an archaeological approach as discussed in *The Archaeology of Knowledge* by Foucault (1969), and also incorporated ideas from Foucault's genealogy approach, particularly Foucault's understanding of power, whereby power produces subject positions and 'truth'. (Stevenson & Cutcliffe, 2006; Tamboukou, 1999).

4.5.2: Analysis of Statements: Strategies, Social Practices, and Subject Identities

In *The Archaeology of Knowledge* Foucault (1969) outlined four categories for analysing statements and discursive formation, these are: objects, subject identities, concepts, and strategies. For the purpose of my research, I have chosen to primarily focus on subject identities and social strategies or practices because I think these two aspects of Foucault's analysis are the most relevant to my research topic. Limiting my analysis to these two areas also helped me to narrow my focus area, as my topic is broad, and this was helpful in giving further definition to my research purpose. Stevenson and Cutcliffe (2006) broadly described this as the mapping between the sayable (statements) and the visible (roles/subject position in society and social practices).

Strategies or social practices refer to the professional and social strategies, generally reinforced by social norms, which guide the practices of care, treatments, and responses to mental illness and employment concerns. As I examined the discourses embedded in social structures, including mental health services, employment services, and economic structures, employing the concept of social strategies or social practices offered a way to examine the responses, treatment options, and programmes supported by these social structures.

The focus on subject identity and subject positions allowed me to examine how participants' subject identities were constructed and how they chose to resist, adapt, or accept discursive constructions of their identity. This allowed me to further understand how discourse impacts the experiences of individuals with mental illness. When analysing subject positions, these included subject positions such as: employer, manager, employee, support worker, individuals with experience of mental illness; however, participants were understood to have multiple subject positions, some opposing, or complementing one another. It was also understood that discourse would privilege certain subject positions, giving authority to subject identities in some areas while marginalising others (Nicholls, 2009). By focusing my

analysis on social strategies and subject identities, I was able to explore my research question regarding how discourse is embedded in the social structures of mental health and within economic structures that impact the experiences of individuals with mental illness.

It was important for my research that I gathered discursive formations surrounding work, economic structures, mental illness, and mental health services from diverse subject identities and participants. This was in part inspired by the Foucauldian discourse analysis research of Ringer and Holen (2016) who examined the numerous discursive formations interacting within two mental health institutions in Denmark, looking at both the discursive formations embedded within mental health practice and understood by mental health professionals, as well as how they were interpreted and responded to by individuals with mental illness within those institutions. Ringer and Holen's (2016) research contributed to my understanding of discourse, power relations, and subject positions, particularly seeing how these impacted the relationship and subject positions of mental health professionals and clients or individuals with mental illness in that research. Following my review of Ringer and Holen's (2016) research, I decided it was important to gather participants with a range of subject identities in order to see how power was embedded within the structures, and also to see how discourse was drawn on and interpreted and how this reinforced particular understandings and subject identities.

My methodological framework, using both archaeological and genealogical concepts, allowed me to focus on discursive strategies embedded within structures and how these interacted with individuals with mental illness, and gave me enough structure to manage my sometimes somewhat unwieldy, broad topic. The broadness of my research topic, examining discourse of mental illness and discourse of work, and how these impact the experience of individuals with mental illness, meant that I had greater flexibility to approach my gathering of data and my analysis. This allowed participants to engage with the research topic however they wished to, with occasional prompts or questions guiding them.

4.6: Research Process and Methods

My research process began in February 2017, with me setting out to articulate my research area and question and formulating my methodology. Initially my primary focus was concerned with examining discourse embedded within economic realities and structures, looking at unemployment and how it impacts individuals. I had thought to examine this

through disability but quickly chose to focus primarily on mental illness as this felt more personally compelling and interesting to me given my experience supporting my close friend. Initially, I was not very clear on my choice of methodology. I knew I wanted to examine the structural responses to mental illness and employment concerns, and I was attracted to discourse analysis, but I was not sure how to proceed with Foucauldian discourse analysis. However, through a process of reading, examining literature, and untangling aspects of Foucault's ideas and practices and various interpretations thereof by other researchers, I chose a Foucauldian methodology. This methodology was a source of confusion at times but also a huge resource of ideas, concepts, and processes to apply to the research project. Once my research topic area and methodology were decided, I submitted a research project application and ethics application, and following approval for these, I proceeded to the next step of gathering participants and documents to analyse.

The process of gathering participants and documents began in July 2017, with the intention to gather a diverse group of participants with differing subject identities and also a range of publicly available documents. The information sheet that I used to inform potential participants of this research is attached in Appendix A. The consent form that participants signed is attached in Appendix B. I chose to use both interviews and documents for analysis in this research project as I wanted to be able to examine the discursive formations impacting social structures broadly, and documents provided a means to do this. For example, mental health organisations' websites captured the discourses embedded within their social practices and treatment options offered for individuals with mental illness, whereas individual interviews illustrated how dominant discursive formations were impacting individuals and their subject identities. Documents were also able to fill in some gaps in my research area; when I was unable to gather particular participants I had hoped to interview, I used documents to substitute some of this data.

In order to map the discursive formations and power acting on the experience of individuals with a mental illness in their work life, it was necessary for me to gather diverse participants who held different subject positions and different places of authority. It was essential to me to have participants with experience of mental illness in this research project, as well as participants working in mental health. In order to understand the economic and work discursive formations, I also wanted to have participants who were employers, managers, or working in human resources. The diverse participants with their various subject positions would allow me to analyse the power relations across these different areas. In terms of

relevant documents for this research, I initially focussed on media pieces, sourcing recent articles that explored elements of my research topic to gather some of the broad, societal discursive formations surrounding employment and mental illness. As I proceeded with gathering participants, my document choices also became a way to compensate for areas in which I did not gather the participants I had hoped to. For example, because I did not end up with many participants from mental health services I used documents, particularly from mental health service websites, in order to map and analyse discourses embedded within mental health services.

For the purposes of this study, interviews with participants with experience of mental illness were essential to enable me to discover the discursive frameworks acting on their experiences at work and their broader social reality. I sent out my research information to local peer support group organisations, emphasising my recognition that participants with experience of mental illness needed to feel comfortable and safe discussing their experiences of work. Peer group organisations were asked to either forward the email discussing the research to their membership or discuss it within their peer groups; sharing my contact information so that any potential participants could contact me with questions and let me know if they would like to participate in the research. From this process, I was able to gather four participants with experience of mental illness, all of whom felt well enough and comfortable to discuss with me their experience of their mental illness and how it impacted their working life. Three of these participants were members of a peer group, and one was a support worker and organiser of the peer group, who also had experience of mental illness.

Next, I attempted to gather participants working in mental health organisations; health professionals, social workers, or support workers would have been suitable participants. I made contact with several non-government mental health organisations, emailing them my research aims and process and asking managers and chief executive officers to forward the information to their staff with my contact details so that potential participants could contact me directly with questions if they would like to be involved. The response from managers and chief executive officers to my research was positive and supportive, however, I received no interest from general staff. This was a disappointment as it did not fit with my initial research plan. I did not anticipate or appreciate how busy staff are within mental health organisations, and I expect that this was a significant barrier. Following this unsuccessful attempt at gathering participants working within mental health organisations, I reassessed and decided to attempt to gather participants working in supported employment organisations.

Gathering participants working in supported employment organisations was a natural fit with my research topic and one I initially overlooked due to my focus on mental health organisations. Supported employment organisations support individuals into employment, generally individuals who have been out of the workplace for a period of time or individuals who struggle to sustain work due to an illness or disability. Again, I contacted supported employment organisations via email, often following the email with a phone call to make sure the email had been received. I asked administrators and managers if they could forward my research information to staff with my contact information so that participants could easily contact me with questions if they would like to be involved. From this, I gathered two participants working in supported employment, both of whom were employment coordinators who supported a number of clients with various physical, mental, and psychiatric disabilities into employment.

The last three participants for my research project came through a mental health organisation that focuses on providing health promotional information, education, and workshops for employers and employees on mental illness and mental health in the workplace. One participant I gathered from this organisation had a history of mental illness themselves and, also due to their role, had a broad understanding of mental health and mental illness in New Zealand. This participant then contacted various employers and managers they had worked with regarding my research. From this, I was able to gather two additional participants from one business; one participant worked in human resources and the other participant was a manager within this business. I gathered a total of five participants with experience of mental illness, two of these participants also worked in mental health, one as a support worker running the peer groups and the other was involved in education, research, and health promotion related to mental illness and mental health in the workplace. In addition, I had recruited two participants working in supported employment and two participants working within a business. In total, I gathered nine participants and conducted eight interviews as the two participants working within the same business wished to be interviewed together.

4.6.1: Interviews

I conducted eight interviews, each of which lasted for approximately one hour. The interviews were both fascinating and challenging to me as a researcher. The eight interviews were semi-structured and focused on particular themes influenced by my review of literature.

The broadness of my research topic meant that I had greater flexibility to approach the gathering of my data and my analysis. This flexibility also meant that within the semi-structured interviews participants could engage with the topics, with occasional prompts or questions guiding them, while also developing their own unique narratives. I have attached my interview guidelines and question prompts in Appendix C. The general themes explored in the interviews included work, the impact and experience of mental illness on employment, the experience of unemployment, barriers and challenges to employment, disclosure, and accommodation of difference and disability in the workplace. These broad themes guided the interview process.

The five interviews with participants who had experienced mental illness were certainly the most challenging interviews for me as a researcher. The vulnerable and difficult experiences of participants with mental illness were confronting and hard to hear. As a researcher, I remained focussed during the interviews, but I did feel sensitive afterwards. One interview in particular was hard as the content and experience of the participant reminded me strongly of my friend's experiences. Interviewing the other participants was considerably less confronting, although all interviews were revealing. I had made particular assumptions when I began this research process and, in particular, I came to realise how much I had relied on a medical understanding and discourse of mental illness as this had helped me understand my friend's experience. However, through the process of undertaking interviews and gathering documents, I found some of my assumptions and ideas around mental illness were challenged and I had to reassess my own assumptions surrounding mental illness.

4.6.2: Documents

Documents selected for analysis included media items, specifically recent media items focussed on employment concerns and mental illness, and website material particularly produced by mental health organisations, advocacy organisations, and some government departments. The documents were selected to examine broad, dominant discourse impacting the experience of mental illness as well as the subject identity of mental illness. Some documents were also selected in part to balance having fewer participants than I had anticipated who were working within a mental health organisation. These documents also provided a way to illustrate which dominant discursive formations individual participants engaged with, and which of these participants resisted or adapted. For example, participants

with experience of mental illness often resisted or adapted discourses that were present within the media surrounding work, offering alternative or resistant discourses.

4.7: Process of Analysing Transcripts and Documents

My data analysis began during the interview process. While I was transcribing the interviews, I was simultaneously starting analysis and also gathering relevant policy documents and reports, media items, and website material for analysis. The initial analysis revealed a number of key themes and discursive formations that reflected discourses already highlighted in the literature review. The interviews and document analysis also revealed contradictory, resisting discourses, and adaptations of discourses, which highlighted the complexity of this topic area. In the following chapters, the findings from the data analysis show how numerous discourses interacted with the experience of individuals with mental illness and show how various discursive formations resulted in different subject identities and personal beliefs, as well as different strategies of management, care, and control for individuals with mental illness in the workplace and in non-work settings.

The analysis process was challenging for me as a researcher as it revealed my lack of clarity around Foucault. It was much easier when analysing material to focus on discourse in a descriptive sense, looking at language use and how it was used to explain and describe experiences or people. I found it much harder to examine discourse in a broader, Foucauldian sense, to not look at what was said, but to examine why something was said, why one statement was made instead of another. I started by examining the context and content of what was said, and gradually my analysis and understanding developed so I was able to better examine the discursive frame surrounding the statements. Still, I regularly faltered and had to revisit Foucault, and remind myself of my research purpose, intention, and process. I gathered so much material from the interviews and selected documents that it was very easy to get lost in it all. However, I persevered, and my analysis developed, and the findings presented in the next two chapters are the result of an untangling and battling with Foucault and all the rich data I gathered.

Several decisions I made using my Foucault-based methodology had an impact on the shape and analysis of the data. Specifically, I chose not to use pseudonyms for participants or name them beyond their subject positions. According to Foucault, the subject or participant is not considered the source of discourse or discursive formations; rather the subject and subject

identity are understood as products of discourse (Garrity, 2010; Kendall & Wickham, 1999). Due to the subject or participant being understood as a product of discursive formations rather than the source, it seemed contradictory to give participants a pseudonym, instead statements stand alone in the findings, contextualised only by the subject identity of the participant. For example, when a statement discussed in the findings was made by a participant working in supported employment, I have stated the subject position of ‘participants working in supported employment’ but the individual participant remains unidentified. The purpose of this is to allow discursive formations to be revealed through the statements, rather than reading into the context of participants or documents; the statements stand alone.

Additionally, within the findings and analysis I have chosen to not examine or note the gender of participants. While gender does offer an additional way to explore the impact of discourse and discursive formations on subject identity, I decided to not include this in my analysis. This is again, in part, to observe discursive formations through statements alone but also because gender is outside the scope of my research topic. While gender may have provided some additional insight, particularly in relation to discursive formations of work which often are less accommodating to women (Lewis et al., 2007), it would have added further complexity to an already large collection of data and documents within my analysis. An analysis of gender alongside my original research question could be the focus of a larger, future study but given the time constraints of a masters, I chose to not include it.

4.8: Conclusion

The process of choosing a methodology, understanding it, and applying it to my research project resulted in an immense learning curve. Foucauldian discourse analysis provided me with a plethora of concepts, ideas, and processes to explore my research question, and I had to work hard to formulate my own understanding and application of this methodological approach. My methodology developed as the research progressed, and I enjoyed the process. However, the research process was also confronting, with some of my own assumptions about mental illness being challenged, particularly recognising my own contribution to discourse that excludes and marginalises individuals with mental illness. The research has also been emotional; certain stories and reflections that participants, particularly those with experience of mental illness, shared, their struggles, their humour, their loneliness, and the

way they stoically carried on, reminded me of my close friend. It was sometimes hard material to engage with. Equally, some of the documents, particularly some media articles, made me angry. My response to the material and personal engagement with the issues, while difficult, also maintained my motivation, especially when I was finding Foucault particularly hard to comprehend.

The analysis of all my research data, gathered through interviews and documents, was at times difficult to sift through, but ultimately resulted in two chapters, one examining the discursive formations around mental illness and the other examining the discursive formations surrounding work. The findings are divided into these two chapters because the data set for this research was large. The first chapter highlights the discursive formations of mental illness that were present within the documents and the interviews I analysed. The second findings chapter builds on the discursive formations of mental illness, placing them within the context of work, and within the discourse of work, and the economic discourse present within the data. The findings chapters represent the culmination of my research methodology and methods, they highlight the discourses embedded within mental health services, and economic structures, and how these discourses are impacting the lives and experiences of individuals with mental illness.

CHAPTER FIVE: FINDINGS: DISCOURSES OF MENTAL ILLNESS

5.1: Introduction

This is the first of two findings chapters. In this chapter, I explore the discourse of mental illness that emerged from the analysis of interviews and documents. Mental illness is constructed in a number of ways by numerous discursive frames, although some are more dominant than others in particular contexts. For example, notably, recovery discourse surrounding mental illness was more dominant within mental health services, whereas participants with experience of mental illness tended to not engage with this discourse. Different discursive formations surrounding mental illness also construct which particular social strategies or responses to mental illness are considered to be most appropriate. For example, within a medical discourse of mental illness, medication is constructed as the appropriate strategy or response to the experience of mental illness.

Most participants and documents analysed drew on a number of discourses to shape their understanding or experience of mental illness. Most participants used both medical and contextual understandings of mental illness to make sense of mental illness. A dominant discourse that most participants also used to explain the experience of mental illness was discrimination discourse. Discrimination discourse and rights discourse are discussed broadly in this chapter as they relate to mental illness, and then within the following findings chapter on work discourse, discrimination and rights are examined more closely as they relate to work, disability discourse, and accommodations.

Different discourses surrounding mental illness additionally construct different understandings of the subject identity of mental illness, and the roles of authority or other subject identities that support the management or control of mental illness. This chapter highlights how the participants with experience of mental illness constructed their subject identities, and how this in turn impacted their engagement with social services, work settings, and within their relationships.

I note the varying discourses regarding mental illness that offer different, sometimes contradictory ways to understand, explain, and make sense of the experience, behaviours, and social realities of mental illness. The discourses that emerged provided particular ‘truths’ surrounding mental illness, included: ‘normal’, ‘non-normal’, and ‘risk’ discourses of mental illness, medical discourse, contextual discourse, recovery discourse, mental health and well-

being discourse, discrimination discourse, and rights discourse. How discourse is embedded within the social practices and subject identities of participants reveals how mental illness is constructed and this impacts the experiences of individuals with mental illness.

5.2: Normal, Non-Normal and Risk Discourses of Mental Illness

While participants and documents drew on a range of discourses to explain and discuss mental illness, a frequently underlying discursive construction of mental illness was whether it was a ‘normal’ part of being human, or whether it was a ‘risk’, or a ‘non-normal’ experience to be managed. One participant with experience of mental illness described mental illness as being like any other illness.

People can’t accept that having a mental illness is like having a normal illness.
(participant with experience of mental illness)

Within this statement, the participant indicated a belief that mental illness is not framed as a ‘normal’ part of life by other members of society. Instead, the participant stated that mental illness is constructed as a ‘non-normal’ illness, whereas other illnesses are constructed as ‘normal’ and therefore more accepted.

People get referred to us and their disability is depression. What human on planet earth hasn’t had depression at some point in their life? (participant working in supported employment)

The statement above by a participant working in supported employment, highlights a discourse of normal surrounding depression. This discourse suggests that everyone has experienced depression and therefore it is common and something normal to expect in life. However, while the participant normalised the experience of depression, there was also a moral judgement in this statement: is depression really a disability that requires support? Everyone has depression at some point, does it really qualify as a disability? While the participant normalised the experience of depression, this normalisation of depression could mean that accommodations are not framed as necessary in relation to the experience of depression.

You’ve got that Swiss airline pilot who flew the plane into the Swiss Alps . . . and that was sort of like, he was on anti-depressants and he wasn’t taking his medication . . . there are some really exploitative connotations around people talking about their

mental illness when it's painted in a negative context. (participant working in mental health)

One participant working in a mental health service organisation also reflected on the broadness of the term 'mental illness'. They noted that though mental illness may be understood as being part of 'normal' experiences, negative connotations of mental illness continue to persist within media representations of mental illness. In New Zealand media portrayals of mental illness, mental illness is framed as both a risk factor, as well as a way to explain difficult, 'non-normal' behaviours. For example:

Porse general manager Kerry Henderson on Wednesday said the company had only just discovered Dengel suffered from post-traumatic stress disorder, depression and panic attacks . . ."This was not disclosed to us, despite this being part of the registration process" . . . "We will be looking into this further and working with our regulators to see if there is more we can do to ensure child safety," she said. (media item) (Clarkson & Truebridge, 2017a, para. 23)

In this example, Dengel had been charged for shaking a baby twice in her role as an in-home child caregiver. In the media item the discourse of risk is apparent; risk to a child could have been prevented, the risks associated with mental illness resulted in harm to a child. Dengel's mental illness was also used as a way to explain how 'non-normal' behaviour in a caregiver role could take place.

While some participants believed that public understanding of mental illness was becoming more accepting, others noted that the media continued to present certain negative stereotypes or versions of mental illness. Participants commented that mental illness is often presented as a risk, a danger, or an abnormal state. In this way, we can understand 'unexplainable behaviours' such as a pilot crashing a plane full of passengers into the Swiss Alps, as discussed by the participant working in mental health.

Another recent media item discussed the "unattractive realities of people who don't fit into a box", noting that while depression and anxiety may be more normalised and accepted experiences of mental illness in New Zealand, other diagnoses are still seen as dangerous (McAllen, 2017, para. 23).

A lot of mental illness isn't silent, it can seem intrusive. Ugly or irritating mental illness is still in the mad, bad, and dangerous to know category and we only celebrate the good ones. (media item) (McAllen, 2017, para. 58)

Conditions like bipolar, schizophrenia, borderline personality disorder (BPD), obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) are seen as scary. (media item) (McAllen, 2017, para. 31)

Within this recent media item, the individuals with mental illness who were interviewed stated that they felt their experience of mental illness was still framed as 'non-normal', or 'bad', in the media, whereas other forms or diagnoses of mental illness, for example depression and anxiety, were more accepted.

5.3: Medical Discourse and Contextual Discourse of Mental Illness

Participants and documents, particularly media documents, analysed tended to frame mental illness within both a medical and a contextual discourse. For example, individuals with mental illness labelled their experience with a medical diagnosis, using medical discourse to explain and make sense of those experiences but they would also often place their experience of mental illness within a context or life event.

One participant working in mental health explained the commonalities and experience of their clients in highly medicalised language.

When someone is unwell, to be diagnosed, you've got to have five to nine symptoms which are clinical markers. (participant working in mental health)

In the quote above, the participant, who worked in a mental health service organisation, constructed mental illness within a medical discourse, but also in the following statement used a contextual discourse to make sense of mental illness.

How they are unwell is very, very similar. How they get unwell and how they process their identification or treatment up to working is all different. (participant working in mental health)

While this participant framed mental illness within the medical discourse of clinical markers, they also have suggested that the process of becoming and managing mental illness is diverse and contextual. This is contrary to a medical discourse of mental illness which would

describe genetic markers or chemical imbalance as a cause of mental illness. Both medical discourse and contextual discourse was used by most participants in framing the experience of mental illness, although medical discourse appeared to be more overt in mental health settings.

Most participants with experience of mental illness used medical terminology to label and construct their experiences of mental illness.

Depression thing for me, and anxiety started about 18 years ago. (participant with experience of mental illness)

None of the participants with experience of mental illness used the phrase ‘mental illness’ but they rather chose to be more specific, and identified their mental illness as anxiety or depression.

Only one participant with experience of mental illness openly questioned the medical discourse of mental illness, particularly the link to medication as primary treatment.

I’m still convinced to this day that in some ways the medication was keeping me down . . . I just found after stopping the medication, I just perked up. (participant with experience of mental illness)

This participant described feeling considerably better after stopping medication. In place of medication as a way to treat their mental illness, this participant discussed alternative ways they supported themselves, which included exercise, gardening, and cultivating other personal interests.

Because someone very close to me took their life, at the same time my sister was diagnosed with terminal cancer, and my partner left as well . . . I was not a happy camper. (participant with experience of mental illness)

Participants with experience of mental illness also tended to describe their mental illness within a context, attaching it to particular life events or circumstances, constructing mental illness within a contextual discourse. For example, one participant discussed the loss of their friend to suicide, alongside their sister becoming unwell, and their relationship failing as a way of making sense of their mental illness.

My brother committed suicide 12 years ago . . . I had a breakdown after the marriage . . . just everything, I basically lost it. (participant with experience of mental illness)

Another participant also discussed the suicide of someone close to them as part of their story of mental illness, as well as the break-up of their marriage. These outside social influences impacting the participants' mental state contradicted a medical discourse of mental illness which would explain mental illness as caused by internal chemical imbalances or genetic issues.

The physical, financial, and emotional impacts of the earthquakes in Christchurch were particular influences that appeared to cause added trauma and stress to some participants who had already been struggling. Several participants with experience of mental illness discussed uncomfortable living situations due to the earthquakes damaging their homes and for two participants the earthquakes also impacted their employment.

It was a pretty awful time anyway because of the earthquakes . . . housing problems, losing a wage job I'd had for 6 years . . . I've moved 35 times since the earthquakes.
(participant experience of mental illness)

Contextual discourse of mental illness was also present in the media portrayals of individuals with mental illness. The media item previously mentioned regarding Dengel, an in-home care-giver who caused potentially permanent brain injuries to a baby, placed her behaviour within a wider context:

Dengel suffered from post-traumatic stress, depression, and panic attacks, but was under financial pressure to work . . . Her family lost its business as a result of the earthquakes, had lost their home and were under financial pressure for her to continue working. (media item) (Clarkson & Truebridge, 2017a, para. 4, para. 19)

In this media item, both medical discourse and contextual discourse were used to identify and explain the behaviours and experience of Dengel. Her mental illness was labelled based on a medical discourse of mental illness while simultaneously her behaviour and mental illness were placed within the context of the Christchurch earthquakes, loss of a home, loss of income and financial security, and the trauma of those experiences.

The broadness of the experience of mental illness means that there are diverse discursive frames for understanding mental illness. While the social and contextual understanding of mental illness has grown, a medical discourse is still present in terms of diagnosis and treatment of mental illness.

5.4: Recovery Discourse of Mental Illness

The discourse of recovery emerged most strongly in the documents analysed, as few participants discussed the concept of recovery. In the documents, it was not always clear if recovery was being referred and understood from a medical discourse or from the recovery model. The recovery model and recovery discourse from a mental illness perspective is different from a medical recovery discourse, although arguably both of these discourses were confused in the data. Recovery in a medical discourse would imply an absence of symptoms and a return to health, whereas recovery discourse frames recovery as an individual journey of being well, managing symptoms, and thriving in life regardless of the symptoms of mental illness. Recovery as a concept and discourse appeared to be more present within professional mental health organisations' framing and discussion of mental illness than in the commentaries of participants who experienced mental illness.

Recovery as a concept and a discourse was present in the materials posted on the mental health service websites explored. The concept of recovery at times remained vague, in terms of what it meant within practice, however, the concept of recovery appeared to shape the values and vision of many service providers.

Our Mission: To contribute positively to the recovery of people who experience mental illness and addictions through the provision of quality community services. (mental health service website) (Comcare Charitable Trust, 2018, para. 2)

Motivated by Christ's love, Stepping Stone Trust journeys with people to find a place of standing, hope, recovery, and wellness. (mental health service website) (Stepping Stone Trust, n.d, para. 5)

In the statements on mental health service websites, the discourse and understanding of recovery was not always clear. Perhaps, as some of these organisations provide services for mental illness and addictions, a more medical discourse and understanding of recovery is intended.

I would look at that as a kind of political movement I suppose . . . starting in the health sector going, hey, stop working with people with mental illness as if it's chronic. You're basically just treating everybody as if they are never going to be back in society . . . The idea that we had to get rid of all our symptoms, for you to be well, and the shift that actually, I want to keep living now. I can actually, I want to be the

best I can, whether or not I am experiencing these symptoms. (participant working in mental health)

The statement made by the participant working in a mental health service organisation constructed mental illness clearly within recovery discourse, and highlighted particularly how recovery discourse challenged medical discourse. Recovery discourse overall appeared less prominent than other discursive frames surrounding mental illness. Instead, the concept of recovery was often framed within a medical discourse, similar to the recovery concept within addiction. Or alternative discourses were highlighted instead, for example mental health and well-being discourse was often used in replace of or alongside recovery discourse on mental health service websites.

Basically, I've got something you can either recover from . . . I actually don't know if you ever recover from it. I asked a psychiatrist at the hospital once, he never gave me a straight answer . . . Well, you need to live with it. (participant with experience of mental illness)

Only one participant with experience of mental illness, not working in mental health, discussed the concept of recovery, although here framing it within the medical discourse of recovery. Recovery was discussed more often within professional settings, for example of mental health service websites, however, the concept and discourse still appeared confused or vague, as it was not generally defined, and appeared to be conflated with a medical discourse of recovery.

5.5: Mental Health and Well-Being Discourse of Mental Illness

As noted, mental health and well-being discourse was often used alongside or instead of recovery discourse on mental health service websites. Well-being discourse and mental health discourse appeared also within the media documents analysed and were discussed by participants working in employment settings.

Part of my remit is to Health and Safety, which includes well-being, and we do quite a focus on mental health through that. (participant working in employment settings)

In employment settings, participants discussed mental health. Mental health and well-being discourse, as noted by the participant working in employment, sat within health and safety policies of employers and were associated with particular social practices including mental

health week and other workshops designed to support well-being. The discourse of well-being discussed by participants working in employment settings, framed mental health and well-being as the responsibility of individual employees to attend helpful workshops and make the most of the flexibility in the workplace.

It's mental health awareness week, so we've got some things happening, things like connecting with nature, smile corner . . . really just the importance of looking after yourself with physical activity, nutritional perspective, and connecting with people, and sharing things. (participant working in employment settings)

Mental health and well-being discourse was discussed by the participant working in employment settings as simple steps of self-care and of taking responsibility for looking after yourself. The employees are 'empowered' to take control of their well-being through attending workshops and looking after themselves, however, the power and role of the employer in the work structures and work expectations is not acknowledged. This discourse can also be seen in 'The Five Ways of Well-being', discussed by the Mental Health Foundation, which provides a guide for improving mental wellness:

Most up-to-date evidence and found that building five actions into day to day lives is important for the well-being of individuals, families, communities, and organisations. The five actions are: 1) Connect, 2) Give, 3) Take notice, 4) Keep learning, 5) Be active. (mental health organisation website) (Mental Health Foundation New Zealand, 2018b, para. 2)

The discourse of well-being and mental health emphasised steps or tasks to achieving better mental health, which were framed as an individual's responsibility and within an individual's control. Although mental health services did also see their role as supporting individuals' well-being as well, as discussed on one website:

We know people's recovery will be faster and more successful if they focus on living well in all areas of their life. That's why our 'Being Well' strategy plays a big part in shaping how we work every day. We don't just focus on people's mental health - total wellbeing is always our goal. (mental health service website) (Pathways, 2018, para. 10)

This mental health organisation used the discourse of recovery to explain their approach and understanding of mental illness, but again from a medical perspective, and adding the focus

on ‘total well-being’, linking to the discourse of well-being, highlighting in this statement to holistic health, or health on all levels.

In considering the prominence of mental health and well-being discourse, it appeared that it was in part supported by neoliberal individualistic discourse embedded within health structures and other social structures. The discourse of well-being and mental health, discussed in the media items and mental health service websites encouraged the use of self-help tools for individuals to manage their mental illness, but did not acknowledge the social, economic, environmental, or political barriers, as well as the inherent power dynamics within relationships and social systems that may be impacting an individual’s well-being and mental health.

The emphasis on mental health and well-being discourse, particularly in the media and websites analysed, can also be seen as a way to make the experience of mental illness more palatable to the wider society. The discourse of well-being and mental health, as already noted, often highlighted responsible individuals, managing their well-being by being engaged with self-help activities, whereas some individuals with mental illness, as discussed in one media item, feel their experience is ignored or silenced.

The truth of mental illness is starkly different to the sanitised narrative seen in 2017. It can wail, rant, be overly intense, rude . . . Mental health advocates . . . In the bid to make people more accepting there has been a focus on mental illnesses that seem more relatable . . . or people who are easier to feel sympathetic towards. (media item) (McAllen, 2017, para. 23 - para. 25)

One individual interviewed in this article described their experience of mental illness as too hard, messy, and frequently not straight-forward, and because of this, they felt that the government and support organisations tended to ignore them.

We get shunted because we can’t be trotted out as problems that can be easily fixed . . . My problems can’t be fixed by 6 weeks of counselling and maybe seeing a psychiatrist every couple of years. (media item) (McAllen, 2017, para. 33, para. 35)

Mental health and well-being discourse suggests individuals that are responsible and engaged in self-help activities can achieve well-being and good mental health, however, the experience of an ‘un-sanitised’ or ‘non-normal’ mental illness, as suggested in this media article, requires more structural and systematic responses. The prevalence of well-being and

mental health discourse in the data appears to be linked and emphasised by the discourse of individualisation which is a dominant neoliberal discourse embedded within social structures. Mental health and well-being discourse also offers prescriptive treatments for becoming well and healthy, reinforced and reiterated by subject identities constructed to have power and authority over well-being, such as managers, employers, and mental health professionals.

5.6: Discrimination Discourse and Rights Discourse of Mental Illness

Discrimination discourse towards mental illness appeared to be embedded within social services and systems based on the experiences discussed by participants and within media items analysed. Whereas rights discourse in response to discrimination appeared to be under-developed or missing, even on the New Zealand Human Rights Commission's website, the discourse of rights in relation to mental illness was cautiously constructed:

It can be unlawful to treat people differently because: (Human Rights Commission of NZ website) (Human Rights Commission, 2017, para. 1)

There are areas where it is unlawful to treat someone different because of a mental illness. (Human Rights Commission of NZ website) (Human Rights Commission, 2017, para. 2)

On the website of the Human Rights Commission of New Zealand, mental illness was discussed separately from disability, and no definition of disability was offered. The Human Rights Commission's website constructed the rights of individuals with mental illness in a particular way, whereby rights were not discussed specifically as they related to mental illness, rather certain actions 'could be unlawful'. This was noticeably different from the rights of individuals with disability discussed by the Human Rights Commission, which were instead discussed actively as 'your rights'. For individuals with mental illness, the language of 'rights' disappeared and was replaced with 'unlawful'. The difference in how rights are framed by the Human Rights Commission suggests that individuals with mental illness do not necessarily always qualify for the same rights as individuals with disability.

None of the participants with experience of mental illness discussed their entitlement to rights in the workplace or elsewhere, except for one participant who also worked in mental health. However, the experience of discrimination was something that all participants with experience of mental illness discussed and in doing so they highlighted an absence of their

rights being taken into consideration. Discrimination was discussed in-depth by participants working in supported employment, however, they did not discuss this experience in relation to human rights except to say that they had not contacted the human rights commission after observing discrimination happening to their clients within workplaces.

It's not a road we can afford to go down. I mean if we start defending clients on a legal level, and then they get. . . I mean, who wants to work for an employer where you've had to muscle your way in legally? (participant working in supported employment)

The participants suggested that there was a common experience of discrimination, and discrimination discourse attached to mental illness, and, despite this, there appeared to be a lack of understanding and discourse around rights. A lack of rights discourse in relation to mental illness in work settings and other settings suggests that the experience of discrimination and exclusion of individuals with mental illness is not seen as a violation of human rights but is somehow justifiable because the individual has a mental illness. The justifiable discrimination discourse was particularly apparent within work settings, and is discussed further in the next chapter.

The experience of being discriminated against while accessing financial support was frequently noted by participants with experience of mental illness, illustrating discrimination discourse embedded within these services, particularly Work and Income New Zealand (WINZ), the social welfare agency of New Zealand.

When I was at Work and Income, I was trying to hold the tears back and I was feeling very anxious and I was bullied, there's no two ways about it, spoken to very rudely. And then, because I was in tears, I was told, in a big, loud voice, and pointed at, I needed to get myself off to psych emergency. (participant with experience of mental illness)

Being told to "go off to psych emergency" appeared to be used as a way to belittle and shame the subject identity of the participant with mental illness who was trying to access support. The difficulty that participants had in maintaining or justifying their financial support meant they had additional financial pressure to go back to work. One participant observed the number of hoops that had to be jumped through in order to get financial support meant that it was a very draining and difficult experience.

A lot of those organisations that are there to support, to provide financial support, have a system where people are made to jump through many, many hoops to get what they are really entitled to. (participant with experience of mental illness)

A participant working in mental health voiced similar criticism regarding financial support and being on a benefit:

Work is not a goal for everybody, but they are pressured if they are on the benefit because of forms, letters, which are saying, if you don't meet certain criteria you lose your benefit. So that keeps people in an unwell state because we don't necessarily open white envelopes. It's really, really difficult to do basic stuff, to make appointments every 3 months. (participant working in mental health)

A participant working in a mental health service organisation observed that the expectations of Work and Income to attend meetings and fill out forms were often beyond the abilities of individuals with mental illness, especially when they were unwell. The participant appeared to suggest that discriminatory practices and discrimination discourse are embedded within services designed to offer financial support, as they were unaccommodating to individuals with mental illness. This often results in individuals being forced to make desperate financial decisions, such as taking on employment even though the individual is unwell, as in the case of Dengel, the Porse care-giver who shook a baby, discussed earlier (Clarkson & Truebridge, 2017b).

Similarly, other social services, such as housing services, can be seen to be unaccommodating and therefore maintaining discriminatory discursive constructions.

Harris has been suspended from renting a Housing NZ home for a year, as this was the second time she went into arrears in 10 years of renting their houses . . . “We expect all tenants to treat their tenancy respectfully.” (media item) (Hayward, 2017, para. 23, para. 27)

Housing New Zealand, as discussed within this media piece, was described as being unaccommodating towards the experience of Tracey Harris who suffered from post-traumatic stress disorder and depression due to her son dying in the February Christchurch earthquake. She ended up in an insecure housing situation and had to fight hard to not be made homeless. Despite Housing New Zealand being aware of Harris having a mental illness and also having had Harris as a tenant with Housing New Zealand for years, her going into debt twice over the course of 10 years of tenancy meant she was no longer seen as suitable. This lack of

accommodation and empathy to the circumstance of Tracey Harris illustrates systemic discriminatory practices and discrimination discourse, and the continued disempowerment and political and social oppression of individuals with mental illness.

Participants with experience of mental illness and participants working in employment support highlighted the systemic ways in which individuals with mental illness were excluded and discriminated against, and frequently framed as bad or undesirable candidates within employment, housing, and financial services.

5.7: Conclusion

Discourse surrounding mental illness is complex and varied, and frequently diverse discourses are discussed simultaneously even though they may provide contrary understandings of mental illness, for example, often a medical discourse of mental illness exists alongside a social and contextual discourse of mental illness. Some discourses surrounding mental illness tend to be more common or dominant in particular settings or social structures, for example recovery discourse is primarily present within mental health settings, although whether it is a medical discourse of recovery or a recovery discourse of mental illness is debatable and frequently unclear. Individuals with experience of mental illness have to navigate how to engage with all these various discourses and how these discourses impact their 'non-normal' identity. This is especially so because their 'non-normal' identity is subject to control and the power of various authoritarian subject identities including mental health professionals, employers, and managers, who are constructed to have power to manage the risk and non-normal behaviours and non-normal identities.

Discrimination discourse appears to be pervasive and embedded within numerous social structures and social practices, frequently impacting the subject identity of individuals with a mental illness in a negative way, constructing them as powerless subjects that can be justifiably discriminated against due to their potential risk and non-normal identity. While discrimination discourse appeared to be a common experience of participants with mental illness, the lack of rights discourse is of concern as the responses to discrimination appeared to be ones of acceptance rather than of resistance. The 'truths' constructed by the often contrary discourses of mental illness impact an individual with mental illness throughout their life and construct particular ways of understanding their experiences and identity. These discourses can impact on their work-life, economic realities, and engagement with work

settings. The following chapter will examine the discourse of work and other discursive frames that specifically impacted the experience and economic reality of my participants with mental illness.

CHAPTER SIX: FINDINGS: ECONOMIC DISCOURSE AND THE DISCOURSE OF WORK

6.1: Introduction

This chapter examines some of the prominent discourses surrounding work and economic perspectives that emerged from the participant interviews and documents analysed. The discourse of work frequently constructed an individual's subject identity and sense of worth in society. For example, subject identities discussed by participants and within the documents in relation to work were often constructed around ideas about what constituted a 'good worker' and 'productive worker' or not. Participants with experience of mental illness were not always able to participate in work due to their illness as well as due to social stigma and discrimination impacting their ability to access work. Not participating in work, being unemployed, or having to work less falls outside of the dominant work-centric discourse that appears to be embedded within society, which celebrates the 'good worker' subject identity and vilifies the 'unemployed' or 'unproductive worker' subject identity. These oppositional work subject identities mirror the 'normal' and 'non-normal' identities discussed in the previous chapter. Work-centric discourse, as highlighted in participant interviews and the documents analysed, compelled some of the participants with mental illness who had periods of unemployment or had to at times work less to resist or adapt discourses surrounding work, to try to maintain a positive subject identity.

Participants and documents highlighted some of the strategies and social practices embedded within workplaces, particularly workplace flexibility and accommodation related social strategies, and competitiveness and efficiency embedded within workplaces and economic structures. Work/life balance strategies or flexible work strategies were discussed by participants in employment settings as means to ensuring the well-being of employees but simultaneously these strategies were framed positively within the discourse of productivity, as ways of ensuring that staff could be more productive. Understanding of the need for strategies of accommodation in the workplace in relation to mental illness were found to be under-developed by contrast to the understanding of the need for such accommodation in the discourse of disability, particularly visible, physical disabilities.

Disability discourse will be examined in relation to accommodations, discrimination, and considerations of rights, particularly from the documents analysed as only a few participants discussed disability discourse. Mental illness, as already noted in the literature review in

Chapter Three, is considered a disability within the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD), however, the dominant discourse surrounding disability is seen as quite separate from the discourse of mental illness. It is important to examine discourse of mental illness as it relates to disability discourse, as this discourse offers an understanding of the different social and political experiences of individuals with mental illness and those with disabilities. These differences are particularly relevant in a workplace environment and can be seen embedded within social strategies and practices in the workplace.

Many participants, particularly participants with experience of mental illness, discussed accommodations and disclosure in relation to physical illness or disability as opposed to mental illness. Disclosure was prominently discussed by most participants in relation to the comparison of physical versus mental illness, as well as within the experience of discrimination, and the process of disclosure. Most participants had strong views and experiences on disclosure, which is of particular interest as it revealed the status of the subject identity of mental illness in the workplace and how most participants would prefer to hide their ‘non-normal’ identity for fear of discrimination.

6.2: Work-Centric Discourse

The interviews and documents revealed a dominant work-centric discourse embedded in society, particularly within social expectations and social structures, including government services and support services dedicated to supporting individuals into work. Work-centric discourse, as discussed by participants and within the documents analysed, particularly media items, placed work and economic attainments and outcomes at the centre of identity, meaning, social success, and as a solution to social problems.

Most participants with experience of mental illness constructed their work subject identity positively, maintaining the subject identity of a ‘good worker’ or a ‘hard worker’ despite having had periods of unemployment. In this way, participants maintained a positive subject identity within work-centric discourse. Work as a measure of success was also discussed by participants, and in particular participants with mental illness described the contrasting feeling of shame and shock at being unemployed and described pressures to be more successful and achieve more in the workplace through promotion or gaining additional responsibilities. Finally, work-centric discourse, as highlighted in documents, particularly

those published on mental health service organisation websites and as media items, constructed work as the solution to social problems; work itself was a strategy discussed, that could treat poverty, social isolation, mental illness, and other social ills in society.

6.2.1: Work as Social Identity

Participants with experience of mental illness frequently commented on their working life and work in relation to their identity and also their social identity. The discourse of work could construct either positive subject identities for individuals or negative ones, impacting their sense of self, and their sense of value to society. The construction of worker subject identities often depended on the work that the participant was doing, and how they saw themselves, or how they felt other saw them at work.

Okay, I'm not the brightest, sharpest knife in the drawer, well, I'll work hard, which I always have. (participant with experience of mental illness)

Several participants with experience of mental illness held on to a positive subject identity around work, stressing their hard work, countering the perspective that suggests that individuals with mental illness are unable to work or are unsuccessful or unproductive workers.

Identifying oneself as a member of the ruling class doesn't require conspicuous consumption. It requires conspicuous production . . . conspicuous production involves the worship of labour . . . it's about how hard you work. (media item) (Tarnoff, 2017, para. 3, para. 4)

As highlighted in the above quote from a recent media piece, the new measure of status in society centres around how hard individuals are seen to be working, with productivity and enhancing productivity becoming an obsession of work culture and identity. A subject identity that is celebrated is one of a hard worker which is associated with the discourse of productivity.

Several participants with experience of mental illness described work as something they had always done, a fundamental part of their life.

I've always worked, basically since I was twelve, I have worked, you know, after school paper run, pamphlets and that. (participant with experience of mental illness)

Within the work-centric discourse that was drawn upon by participants and within the media items analysed, work shaped how people were understood and valued in society.

An obsession with employability runs through education. Even severely disabled welfare claimants are required to be work-seekers. Corporate superstars show off their epic work schedules. “Hard-working families” are idealised by politicians. (media item) (Beckett, 2018, para. 1)

Work-centric discourse is reinforced and embedded within social structures as noted by the above recent media item that examined the changing shape of work, as well as how it dominates social interactions, and who society values. In contrast, individuals and groups of people who are unable to work or are not working, or are not seen to be making an effort to work are frequently portrayed as negative subject identities, not fulfilling their social obligations.

There was only five years, if that, where I wasn’t working. (participant with experience of mental illness)

Most participants with experience of mental illness discussed having periods of not working, which contested work-centric discourse and their claims to a positive subject identity. While some participants described feeling burdened by the experience of unemployment, and ashamed by it, others carried it lightly and framed it as an exception to their general life course, in this way maintaining that their experience still fit within a work-centric discourse and maintaining a positive subject identity.

I just never saw myself being in that situation, I thought I was going to be able to work until I was old enough to retire and that was going to be it. And then I had to face this reality. (participant with experience of mental illness)

The experience of being unemployed and not working was a shock to some participants with experience of mental illness, changing the way they viewed themselves and their abilities. Thus, being unemployed and not working negatively impacted their subject identities.

In a recent New Zealand media item, mental health conditions were highlighted as one of the principal causes of unemployment for individuals accessing a benefit. The experience of mental illness being linked to unemployment and being on a benefit creates a particular social identity for individuals with mental illness, illustrating the difficulty that individuals with mental illness can have in conforming to work-centric discourse.

Nearly 55,000 people were receiving a benefit for mental health reasons in 2016, making it one of the highest illness or conditions putting people out of work. (media item) (Mcbride, 2017, para. 3)

This media item that framed mental illness or mental health conditions as the experiences that were “putting” individuals out of work, did not examine the inaccessibility and lack of accommodations made by workplaces. It also did not acknowledge social stigma and discrimination that often make it difficult for individuals with mental illness to access and maintain work. Instead mental illness was portrayed in this media item as a cause of unemployment, reinforcing the discourse of ‘non-normal’ and the ‘risk’ discourse of mental illness, and adding the negative subject identity of ‘unemployed’ to the subject identity of mental illness.

6.2.2: Work as the Measure of Success and Productivity Discourse

Working is a measure of success within a work-centric discourse as noted by participants. Generally jobs with more status, full-time hours, other benefits, and greater responsibility were described by participants as illustrating greater success. This discourse of work, while constructing a measure of success also constructs the status and power of an individual’s subject identity. Participants described work that was full-time, or significant roles with responsibility, as ‘real jobs’. However, these ‘real jobs’, high status, and high responsibility jobs, are not always available and accessible to individuals with mental illness for various reasons.

I kept thinking, this is not a real job compared to where I used to work . . . but I’ve found this is my comfort zone, so I’ve stayed. (participant with experience of mental illness)

Work-centric discourse constructs positive and powerful subject identities around productive workers working in the “real jobs”. Not being able to work in a “real job” sometimes, or fulfil the feeling of success as constructed by work-centric discourse, added to the distress and shame some participants with experience of mental illness felt. This is particularly true for participants who had experienced working in what they considered a “real job” prior to their mental illness.

I've had to downgrade a wee bit. This job is a bit ho-hum . . . it's not as stimulating as I'd like but it did really suit me 18 months ago. (participant with experience of mental illness)

The individual pressure and the social pressure, discussed by participants, to have a “real job” or a better, more socially recognised job was often at odds with the health or personal needs of participants with experience of mental illness. Another participant noted that they had chosen a particularly simple, low-responsibility, and low-paid job that suited their needs, although their needs had evolved.

The pressure to succeed . . . and there's opportunities sometimes to become a team leader, manager, or you know, get more pay essentially, but it's like . . . I'm good at what I do, and I don't think at this stage the opportunity to take a management role would be right for me. (participant with experience of mental illness)

Some of the participants with experience of mental illness felt pressured to move up or beyond their current work position by their employers and by colleagues. Being socially compelled to have greater success was an occurrence discussed by several participants with experience of mental illness. The pressure from employers and from colleagues for individuals to take on more responsibility in their work, which might lead to more pay, was both exciting and intimidating to participants. Participants generally described feeling resistant and hesitant to take on the extra responsibility and workload associated with the ‘better’ positions.

Productivity is the great preoccupation of our age. The productivity industry is thriving. It has its own aisle in all the app supermarkets. (media item) (Cocozza, 2017, para. 2)

The media documents I analysed highlighted a discourse of productivity and the pressure of society to produce more work which formed part of the pressure that participants with experience of mental illness felt. Within work-centric discourse, success in work is measured not only by the status of the job itself but also how productive an individual is seen to be in their work. One media item observed the preoccupation with productivity as symbolic of how work has infiltrated all aspects of social life, as all activities can be reframed as tools or strategies to enhance an individual's productivity in work. As some of the participants with experience of mental illness noted, they were not always able to achieve or maintain the

status of high productivity, and they therefore had to try to resist or adapt this discourse of high productivity.

Workplaces can be really output driven . . . it's that high achievement focus, and so, if you've been off work for two days with a cold or whatever, you know you feel that type of culture where you are not pulling your weight. (participant working in mental health)

One participant working in mental health, who also had experience of mental illness, observed the social pressure that came with “not pulling your weight” and not reaching the expected levels of productivity and explained how this impacted their feelings of worth in a workplace. They attempted to resist this discourse of productivity and this limited view of success at work, by thinking of their strengths in other areas, thereby maintaining a positive subject identity.

Work-centric discourse, as highlighted by participants and media items, constructed work as a social identity, and a measure of success and status for individuals. Alongside this construction of work, the discourse of productivity, noted by participants and in media items, suggests that individuals not only have to work but they have to work hard and create measurable outputs. Participants with experience of mental illness discussed that they could not always perform to the expectations of being highly productive in their workplaces, in which case, they might be perceived by employers and themselves as not being successful employees, and thus labelled with a negative subject identity of a poor or unproductive worker.

6.2.3: Work as the Solution and Work as a Strategy

Work-centric discourse also constructs work as a solution and a legitimate strategy to a variety of social ills particularly within the documents analysed but also by participants. Work was constructed as a way for individuals to be included and participate meaningfully in society. By contrast, being dependent on welfare and not working was considered to be sustaining a social ill.

MSD's stated aim is to “help New Zealand help themselves”. But creating thousands of welfare-dependent beneficiaries isn't a long-term solution. (opinion piece) (L. Hunt, 2018, para. 1)

In a recent opinion piece, written by an individual who was previously on a benefit, Work and Income New Zealand (WINZ), the social welfare agency of New Zealand, was framed as creating dependency rather than upskilling individuals and encouraging more work opportunities.

Work-centric discourse within this media item, constructed unemployed individuals on a welfare benefit as “dependent” on the welfare state. Such framing of unemployment, fails to acknowledge any economic or social structures contributing to difficulties in gaining employment by constructing unemployment as the fault of the individual. The pressure to work and be seen as a positive subject identity was strongly felt by participants with mental illness.

They are pressured if they are on the benefit because of forms, letters, which are saying if you're unemployed or you're a job-seeker or whatever . . . if you don't apply for certain things or you don't meet certain criteria, you will lose your benefit . . . so that really keeps people in an unwell state because we don't open white envelopes.
(participant working in mental health)

Individuals with experience of mental illness noted the coercion and pressure to work, rather than themselves appearing to believe that work was an obvious solution to their needs, as was also apprehended by a participant working in mental health services. Welfare structures, according to this participant and other participants with experience of mental illness, appeared to be embedded with work-centric discourse that promotes work as both a solution and a necessity. While participants generally described a desire to work, many felt pressured to work, both out of financial necessity, and because they felt pressured by government organisations, and that often increased their stress and anxiety about obtaining or maintaining work.

I was in sort of two minds. I was trying really hard to get back into the workforce and the other thing was telling me that maybe I'm not ready for it. (participant with experience of mental illness)

Several participants observed a contradiction in feeling a need to work but also not feeling well enough to work. Navigating a work-centric discourse that celebrates working subject identities and vilify unemployed subject identities created social pressure on participants with experience of mental illness, who at times needed time off work for their health or experienced periods of unemployment due to their mental illness.

Like Minds, Like Mine, a National New Zealand campaign dedicated to combating stigma and discrimination around mental illness, also reiterated a work-centric discourse, framing work as a solution and a positive strategy towards health on their website.

Employment is key to recovery. Having a job is good for your health and sense of self. It helps you feel socially included, financially independent, and gives you a sense of purpose. (mental health organisation website) (Like Minds Like Mine, 2016b, para. 1)

In work-centric discourse, work is framed as essential to the recovery and well-being of individuals with mental illness. Generally participants with experience of mental illness discussed and resisted work-centric discourse, however, several participants with experience of mental illness did also discuss work as a solution and something that positively supported their experience of mental illness.

It was basically to have someone to talk to, I'd rush to work to have someone to talk to. (participant with experience of mental illness)

Another participant similarly observed:

Work, that's my main contact with people I suppose . . . it was incredibly isolating, I was pretty isolated before I worked. (participant with experience of mental illness)

Without work, some of the participants with experience of mental illness described how they felt very alone and excluded from society, and in this way work was constructed by some participants as a legitimate strategy for helping them feel like an active and valued member of society. One participant noted that they would often over-work, by working longer without additional wages, as a distraction and to have a place to be for company.

When I had nothing to do, I kept thinking, I'm heading towards the gutter. (participant with experience of mental illness)

This participant with experience of mental illness would sometimes arrive at work several hours early, to "make coffee" for their work mates in order to avoid the feeling of having "nothing to do".

The main thing about work, before the financial thing, is that it stops you from thinking about anything else . . . about your stuff. (participant with experience of mental illness)

Other participants with experience of mental illness observed that work provided a good distraction; they constructed work as an escape from their mental illness and their personal concerns. For some participants, work and working were part of a strategy that supported them to feel okay in society.

Based on participant interviews and the documents analysed, work-centric discourse appeared to be so thoroughly embedded, that not working and having the subject identity of being unemployed was often difficult to manage alongside the already stigmatised identity of having a mental illness. While work, as noted by participants, could offer stability, economic security, and a helpful distraction, it was also often a source of discrimination, bullying, lack of accommodation, and expectations that left participants with experience of mental illness feeling unwanted and unable to perform successfully in their roles.

Similar constructions of work were found in the media items analysed. A media piece released by Access Alliance, an organisation advocating for better access legislation to support people with disabilities in New Zealand, reinforced work-centric discourse by framing work as an important solution and social strategy to support individuals with disability. Access Alliance released a report regarding the social and economic benefits of making work more accessible to people with disabilities.

The report, ‘Valuing Access to Work’ by the New Zealand Institute of Economic Research, said better support of disabled people could cut welfare benefit costs by \$300m a year and increase tax revenues by \$387m. (media item) (BrettKelly, 2017, para. 4)

In contrast to being unemployed and having individuals with disabilities on the benefit, the above media item constructed work as the clear solution for individuals with disabilities and also for the wider economy. The media piece focused on the economic benefit of having more individuals with disabilities working rather than being on the benefit.

It’s time to look at how we can enable disabled people to participate in the community and economy, rather than focusing on the costs of managing disability issues in the traditional way; one person at a time. (media item) (BrettKelly, 2017, para. 9)

This media item discussed work as a solution, highlighting particularly the economic benefits of having individuals with disabilities working. The media item also emphasised the structural barriers have limited employment opportunities for individuals with disabilities,

noting the collective responsibility of the New Zealand government and workplaces to make work more accessible to individuals with disabilities. This emphasis on ensuring accessibility is consistent with the social model of disability and disability discourse, ensuring that social and physical structures are not disabling individuals. However, the structural approach that was highlighted within this media item, was not apparent within approaches or discussions around how to support individuals with mental illness in accessing work. Disability discourse and mental illness discourse are examined further in a later section in this chapter.

6.3: Work Resistant and Adaptive Discourses

While participants with experience of mental illness often endorsed a work-centric discourse, they also discussed ways in which they resisted or adapted work-centric discourse. Resisting dominant work-centric discourse was necessary for participants with experience of mental illness who were sometimes unable to conform to the expectations of this discourse. This also afforded participants a way to maintain a positive subject identity. There were two distinct ways in which participants with experience of mental illness resisted or adapted work-centric discourse: either they stated that work was not their primary focus, or they framed unemployment as a necessity of managing their well-being.

6.3.1: Work is Not the Primary Focus

Participants with experience of mental illness frequently adapted work-centric discourse, often in order to meet and manage their health needs.

Work is not number one anymore, I've always worked, probably overworked, used work as a distraction . . . basically I've got a home life now, which I've lacked for years. (participant with experience of mental illness)

One participant noted the greatest shift in their personal life came from starting to focus on their own interests and activities outside of work, therefore resisting a work-centric discourse. Previously work had been the primary focus of their day, often used as distraction from their mental illness; they were prone to overworking.

I just want to go there, do a good job, and go home . . . that's all I want. (participant with experience of mental illness)

Generally participants with experience of mental illness discussed wanting to have separation between their personal life and their working life. Partially this was due to some participants feeling unable to disclose their mental illness at work, but it was also part of a way of relating to work. Work was framed by some participants with experience of mental illness as being a secondary consideration to their personal needs and their mental illness. Work not being framed as a primary feature of identity and the primary way of engaging in the world was a clear adaption of the dominant work-centric discourse. In this adaptation, while work was still constructed as important by participants with mental illness, it was framed as being secondary to their health.

6.3.2: Not Working as Central to Well-Being

A more active resistance to work-centric discourse consisted of framing the act of not working as important to well-being. This discursive framing of unemployment was discussed by some participants, although sometimes apologetically whereby they showed that while they were shaping an alternative discourse to work, this was not a dominant one that participants believed would be heard empathetically.

I really, really struggled for probably the first five years . . . I took mental health days . . . I explained to my boss, there is just days where I can't get out of bed. I'd wake up and I couldn't face work today. And he understood. Unpaid you know, but I've got to do it. That sort of dwindled out over the years. (participant with experience of mental illness)

Having time off work or periods of unemployment was sometimes a necessity for participants with experience of mental illness. Some participants with mental illness framed their experience of being unemployed, or not working full-time, or having to take leave as a necessity for their health. They prioritised their needs over the expectations of work.

My wellness was my full-time job. (participant with experience of mental illness)

Participants with experience of mental illness reframed being unemployed as a necessary part of their well-being, rather than seeing it as a circumstance to be socially ashamed of. This perspective was subversive to the dominant work-centric discourse. While the experience of unemployment was certainly challenging for all participants with experience of mental

illness, some participants were also able to challenge the idea that work was their only valid contribution to society.

My most dreaded question, which is if you go out somewhere and you're meeting someone new or whatever, the first thing that they'll say to you after they know your name is 'Oh, what do you do?' and when I wasn't working, I thought, please don't ask me that...I don't know what to say. (participant with experience of mental illness)

Another participant with experience of mental illness also observed the value that society placed on work, and work being a defining feature of an individual's life. They resented this, especially when they were not working, and they described the feeling of judgement and how they tried to resist the need to explain their work circumstance as a way of explaining their identity.

A recent media article highlighted a growing challenge to work-centric discourse, focusing on post-work society, as the role of work in society appears to be 'failing'.

Work is not working, for ever more people, in ever more ways. We resist acknowledging these as more than isolated problems – such is work's centrality to our belief systems – but the evidence of its failures is all around us. As a source of subsistence, let alone prosperity, work is now insufficient for whole social classes. (media item) (Beckett, 2018, para. 3 - para. 4)

This media item highlighted the growing interest and awareness of how work could be done differently, as well as looking at life beyond work as the central focus. These resistant discourses appear to be growing in number, and challenge the centrality of work in our society and also attempt to provide new subject identities and understandings of how individuals can meaningfully contribute and participate in society outside of work.

6.4: Evolving Work Practices and Strategies

Work practices and workplace strategies are indicative of the discourses embedded within work. Discourses embedded within workplaces result in particular strategies being undertaken and are seen as credible ways to manage employees and all aspects of work. Within the interviews and documents analysed, several workplace strategies or policies were discussed, some of which centred around the discourse of employee well-being, and others of which were driven by the discourse of productivity, efficiency, and competitiveness.

6.4.1: Workplace Flexibility and Accommodation Practices

Participants working in human resources and employment settings were the only participants who directly referred to the concept of work/life balance and flexible work practices when discussing mental illness and mental health in the workplace.

Our Flexible Working Policy, so our CEO and leadership team really championed and supported themselves, flexible working...means making sure that work fits in, that it balances between your life and your working life. So, for example, people were encouraged to go to the gym at lunchtime, or if you need to leave early to look after your children. (participant working in employment settings)

One participant working in employment settings highlighted a particular piece of organisational policy which reflected the idea of work/life balance; this policy aimed to give employees a way to balance their personal life and their working life. While participants working in employment settings noted that the flexible working policy was good for staff well-being, they also noted that it made good business sense as well, as happier staff were more likely to remain with the company.

Most of the participants with experience of mental illness did not discuss workplace flexibility, work/life balance, or workplace accommodations directly. Only one participant with experience of mental illness discussed how their employer was very flexible and accommodating of their needs. They had experienced this flexibility as they had frequently had to take days off work over several years.

My boss had a bit of an understanding because his wife's son had committed suicide . . . I think that helped him understand my situation better. (participant with experience of mental illness)

This participant felt that their boss was particularly empathetic to their mental illness and needs in the workplace because the boss' wife's son had suicided. This was also the only participant with experience of mental illness, not working in mental health, who had disclosed their experience of mental illness. The majority of participants with mental illness did not discuss accommodations or workplace flexibility around mental illness in the workplace as they had chosen to not disclose their mental illness to their employers. Being accommodated in the workplace appeared to be more likely when an employer had a personal

understanding of mental illness, but it is also significantly related to disclosure, which will be discussed further in a following section.

Having a boss with a greater understanding of mental illness allowed this participant with experience of mental illness greater flexibility and accommodation in the workplace. However, the participant's 'mental health days' or days off, which were supported by their boss, were also unpaid, so their experience of workplace accommodation of mental illness was still limited and confined within the belief that if a business afforded mental health leave in the same way as it afforded sickness leave, then it would not be financially viable.

6.4.2: Efficiency and Competition Strategies and Discourse

Many participants observed how work had changed over their lifetime, particularly observing growing competitiveness at work. Work was frequently described as harder than it used to be.

It's so competitive, I'm really old school and I found it . . . anyone would find it challenging as they got older, but it really put me on the back foot. (participant with experience of mental illness)

Participants with experience of mental illness felt that the work environment had become more competitive and that employers had higher expectations of them, and this belief was held especially by participants who were slightly older and who therefore had historical experience of work. Another participant with experience of mental illness observed that the government support around finding employment had also changed.

But it was easier for people back then too because you know, the government used to help people wanting to get back into work with training, it's a bit out of reach for people now. There are more things that I'd actually like to do and sort of diversify but it's not financially viable. (participant with experience of mental illness)

This participant described how they had in the past accessed support from the government to do additional training to diversify their skills, but the government currently did not offer the same supports to help individuals gain an edge in the job market.

Several participants also observed the growing lack of human connection involved in both the employment process but also within the labour market. A lack of human connection was described by participants with experience of mental illness and by participants working in

supported employment. They considered that this enabled workplaces to treat their employees as expendable if they did not meet a set of measures such as competencies, rather than seeing them as a person.

It's probably not the best place for someone with a mental illness . . . the whole company structure, it's a very big international company . . . and you are literally a number. (participant with experience of mental illness)

One participant with experience of mental illness recalled one of their first experiences of working for a “neat, old fashioned company . . . that was almost like a big family” which they compared to their current job where staff were all literally a number. The participant described themselves as a number in the workplace now, rather than being seen as a part of a family or a valued member of the team. This participant noted that were potentially expendable to their current workplace.

Being easily expendable meant that if a participant with a mental illness was not performing well at work, unable to compete within their work settings, or otherwise unable to fulfil their work expectations, then they could be easily let go of. This was a trend discussed in a recent media piece mentioned previously, discussing the growing number of jobs that are contract-based, casual, and precarious:

Work is increasingly precarious: more zero-hours or short-term contracts; more self-employed people with erratic incomes; more corporate “restructurings” for those still with actual jobs. (media item) (Beckett, 2018, para. 6)

Precarious work for an employee allows employers and businesses to have greater flexibility and be able to compete and respond quickly to market place demands, in this way being a more efficient and competitive business.

Participants working in supported employment also observed the lack of human connection in the employment process, which they described as being eroded by centralisation and a drive for efficiency.

More and more employers are telling us to go to the website, you've got to apply through the website. There's no face-to-face point of contact you know? . . . The corporate policy and mandate is they have to go through HR and HR is in Wellington, so you have to go through the website . . . so it's centralised. (participant working in supported employment)

Workplaces and businesses being centralised and instituting various other strategies aimed at achieving efficiency has, as noted by participants working in supported employment, meant that individuals with mental illness are less able to meet workplace expectations and may have greater struggles in finding and maintaining employment. The competitiveness and efficiency discourse, as discussed by participants, appears to be embedded within the market economy and businesses, making it harder for people with experience of mental illness to be accommodated with their specific needs.

6.5: Disability and Mental Illness Discourse in Employment

Within the documents analysed, the discourse surrounding disability was more likely to result in workplace accommodations than the discourse of mental illness. The discourse and subject identity of disability is relevant to explore because as noted previously, mental illness and disability are conflated within administrative and legal contexts. Analysed documents and participants working in supported employment more often drew on the discourse of disability, whereas only one participant with experience of mental illness, also working in mental health, identified themselves as having a disability.

Even the word disability, maybe that's half the problem, the names, the titles, the badges we use . . . as soon as you hear that word: disabled, we pigeonhole.
(participant working in supported employment)

As noted by a participant working in supported employment, being labelled with the subject identity of having a disability can make accessing employment harder. As discussed by the participant working in supported employment, the discourse and subject identities surrounding disability can cause problems in accessing and maintaining employment, as often individuals with mental illness or with disabilities are not seen as the competitive choice for employment, and they may struggle to maintain their employment when they have periods of being unwell.

As already stated, only one participant with experience of mental illness discussed the concept of disability. The disconnection between the experience and discourse of disability and of mental illness is interesting, particularly as in some legal and administrative settings they are understood together. Most of the participants with experience of mental illness did not construct their mental illness as a disability.

I didn't think of myself as disabled until I was doing the census one year. . . 'Do you have a health condition that affected you more than 6 months?' Yes. It equated to a disability. (participant working in mental health)

There is confusion surrounding what qualifies as a 'disability'. As noted by the above participant, administrative measures of disability, such as the census data, imply that disability is associated with the length of time a health issue impacts someone's life. However, social model of disability would define this differently.

The confusion surrounding the broadness of the term mental illness and the broad experience of disability meant that the participants working in supported employment stated that they preferred not to engage with the concepts of either mental illness or disability but that they would instead rather focus on the individual client.

It's all individual you know? . . . the style and level of support is entirely based on need. (participant working in supported employment)

If, as stated by this participant working in supported employment, the focus is on the individual client, then, while this does ensure that the client gets the support they need to find work. However, it also means that the structural discrimination embedded within employment settings is not addressed and the collective realities of individuals with mental illness and disabilities are not acknowledged.

Mental illness and disability in terms of services provision were described as distinct and separate. The participants working in mental health services noted the structural and ideological differences between mental illness and disability.

Mental health is separate to disability, funding is separate, services are separate, you've got that separation. (participant working in mental health)

A participant working in mental health services also observed that the definition of disability seemed to go against some of the understandings of mental illness, particularly within recovery discourse.

Disability has this implication of permanency . . . whereas mental illness has pushed that we can recover, we fight against permanency. (participant working in mental health)

On most of the supported employment service websites that were analysed, there was a discussion that revealed the discourse that constructed the subject identity of individuals with disabilities in relation to their services.

Catapult's vision is for all people to have the opportunity to participate in paid employment, including those who live with a disability or health issue. (supported employment service website) (Catapult, n.d., para. 1)

Mental illness was only explicitly discussed on one website out of the four websites analysed.

Many people who have an experience of mental illness recover and can return to work very successfully. To ensure the return to work is as smooth as it can be for everyone, there are some simple ways to provide support. (supported employment service website) (Wisegroup, 2018b, para. 1, para. 2)

Otherwise the job-seekers on the websites analysed tended to be constructed as individuals who may have disabilities or health issues. This is problematic as many individuals with a mental illness do not identify themselves as having a disability and their realities regarding difficulties surrounding employment are therefore not specifically acknowledged.

Most supported employment service websites had specific pages for 'job seekers' or those needing employment support and then a separate page for potential employers. Only one website did not have a specific page for employers. The homepage of all the websites aimed to speak to both audiences although frequently the language favoured the employer, as seen in the statement on the homepage of one website:

Our services are free, and we fill 3500-4000 job vacancies each year. (supported employment service website) (Workbridge, 2018b, para. 2)

There is a clear power dynamic highlighted in the choice of language on the websites analysed, between the potential employer and the potential employee. The supported employment service websites tended to favour the subject identity with more power in the circumstance of employment: the employer. Several websites referred to individuals seeking employment or similar euphemistic terms with little to no reference to disability or mental illness, and this appeared to be a language choice that would be more palatable to potential employers. This disengagement from both mental illness discourse and from disability discourse and associated subject identities suggested that these discourses and subject identities were seen as less employable. The image that was put forward instead was of a

potential employee, an employable individual, someone ready to work who has been overlooked. While this portrayal is not incorrect, the omission of mental illness and disability subject identities does not acknowledge the reality of many individuals with a mental illness or disability who perhaps have not been offered opportunities by employers or they have lost employment because they have been discriminated against or not accommodated in the workplace.

The websites that did acknowledge and name disability almost commodified disability in the eyes of an employer, as something that would increase the value of the company or business. The statements chosen on the websites appeared to be designed to reassure employers, managers, and human resource teams as they highlighted how potential employers were making a good decision.

Why employ disabled people? . . . Employers who leave this talent pool untapped risk missing out skilled, capable, and highly motivated workers. (supported employment service website) (Workbridge, 2018a, para. 1 - para. 2)

The discourse of disability, and lack of mental illness discourse, that appeared to be embedded within most of the supported employment service websites analysed, is likely to impact the subject identities of individuals with mental illness and affect their experience of their engagement with these services. As mental illness is often described separately to disability, this may affect individuals in their ability to ask for accommodations in the workplace. It was also apparent in the data that supported employment services had chosen to engage more with the disability subject identity, therefore potentially isolating and silencing the experience, and needs of individuals with mental illness within the workplace.

6.5.1: Discrimination and Rights Discourse at Work

Rights of individuals with mental illness appeared to be a missing discourse within the documents and interviews analysed, as already noted within Chapter Five. Mental illness is classified as a disability under the *Human Rights Act 1993* and also within the CRPD, however, in practice there is a disconnect, both in terms of how individuals with mental illness are constructed within a disability discourse, and also in terms of the advocacy and awareness of rights provided for individuals with a mental illness (Gordon & O'Brien, 2014).

In contrast to a lack of rights discourse within the participant interviews and documents analysed, particularly in media items, discrimination discourse was present within the workplace and frequently constructed as justifiable. Some discrimination observed by participants was framed using language that seemed to soften the discourse of discrimination.

There's a lot of resistance from employers . . . if there's gaps in CVs or apparent disability, whether it be mental illness or physical disabilities. (participant working in supported employment)

Participants working in supported employment discussed their observations of some of the barriers and structures that impacted their clients in terms of employment opportunities. Participants described the resistance of employers when they found gaps in employment or any mention of physical disabilities or mental illness of potential employees. While participants with experience of mental illness did not specifically mention gaps in their work history impacting their employment, most of them would have had gaps in their work history due to having to take time off work for their health. As stated by the participant working in supported employment, this made them appear less reliable and viable workers, giving them a negative subject identity in the minds of potential employers.

More and more employers are resorting to a digital filter. There's no face-to-face contact, just apply through the website . . . one of the first things they do is a word search, a digital word search . . . looking for keywords, hit rates, things like that. (participant working in supported employment)

Another participant working in supported employment opined that the focus on applying for jobs through a website created new exclusion criteria and was a way of filtered out unwanted candidates as well. While these systems of filtering through job applicants may not have been designed to be discriminatory, they may in fact be inherently discriminatory as they favour the 'ideal worker', which will often be the worker who does not require accommodations or flexibility from the employer.

A recent media item highlighted an example of active exclusion and discrimination in the hiring of individuals with mental illness. The media item discussed the New Zealand Police recruitment policy which prevented access to employment opportunities for individuals with a mental illness who were on anti-depressants. Individuals on anti-depressants were told they would not be able to be part of the New Zealand Police force until they were off their medication for at least 2 years.

Police say that recruits on anti-depressants are in danger of ‘spontaneously’ relapsing. (media item) (Fonseka, 2017, para. 2)

This discrimination is constructed as justifiable by the New Zealand Police, as individuals with mental illness are seen as a risk. Individuals with mental illness within this recruitment policy are constructed as potentially dangerous, non-normal, and therefore the police force has grounds to discriminate against them. The same media article discussed one man’s attempt to join the police force. He was described as being on a low-dose of anti-depressants, which was implied by the media item to mean that he was a low-risk candidate for the role and therefore should be able to be on the police force.

Renwick started taking the drug Citalopram after his father suffered a serious head injury. Renwick became a permanent carer for his dad, and said doctors prescribed a low dose of the anti-depressant. (media item) (T. Hunt, 2017, para. 6)

Renwick’s experience of mental illness was constructed both within a medical discourse, as his depression was treated through medication, and also within contextualised and social discourse, as it appeared to be explained as having resulted from the experience of being a primary care-giver for his father. Despite mental illness being constructed using these diverse discourses within this media item, the underlying discourse within the police policy appears to consider mental illness as a potential risk that can be justifiably discriminated against.

Participants who worked in supported employment discussed several examples of workplace discrimination that had happened to their clients with disabilities but when asked if they had considered supporting their clients through the Human Rights Commission, they never had. Similarly, participants in mental health support service organisations who had supported clients in the workplace had only opted to use the Human Rights Commission in a couple of instances.

If someone’s getting back into the workforce, or working . . . there is usually stuff in their individual contract that covers a lot of that . . . because so many places now our risk-averse, they won’t discriminate . . . however they will discriminate covertly . . . so it might not be because you’ve got a mental illness, it might be that the 90 day trial period, what’s that about you know? So, they will find a performance thing.
(participant working in mental health)

There was an understanding that discrimination in the workplace was a legal issue. However, participants in both supported employment services and mental health support services

appeared to consider the matter to be outside their role, and they did not appear to think that challenging such discrimination would be a helpful option. There was also a persistent idea that, depending on the shape of contractual obligations, discrimination might be able to happen legally. The entitlement to rights held by individuals with mental illness in the workplace was not discussed.

[When asked if discrimination was a legal issue.] Well, it depends on the contract . . . you can put stuff into the contract that you are subject to. (participant working in mental health)

Exploring websites of supported employment organisations revealed similar results in terms of those organisations' relationships with rights and their understanding of discrimination.

Can I be discriminated against because I have a mental illness? The law says you have a right not to be discriminated against in employment on grounds of race, gender, age, religion or belief, sexual orientation or mental illness. (supported employment service website) (Wisegroup, 2018a, para. 12)

Only two of the four supported employment websites analysed mentioned rights, discrimination, and reasonable accommodations in the workplace. Of the two websites that mentioned rights, discrimination, and reasonable accommodations, only one had explained these ideas in practical ways by describing practices or strategies of accommodation, and made them easy to find on their website. The discourse of rights in relation to mental illness was shown to be underdeveloped, especially when compared to the discourse of rights and accommodations of individuals with other forms of disabilities. This is likely to be at least in part due to the greater visibility of some disabilities over others.

6.6: Visible and Invisible Identities: Physical Vs Mental Disabilities

The difference in perceptions about disclosing a need for physical accommodations versus disclosing a need for psychological accommodations was something all participants with experience of mental illness discussed, and that both participants working in employment settings also noted. Participants thought that having a mental illness was harder to discuss and disclose than a visible physical limitation would be, and that the latter would also be easier for people to understand.

The difference between how a visible physical ailment or disability constructed an individual's subject identity and how an invisible mental health issue constructed an individual's subject identity was a source of frustration and shame to participants and impacted what they disclosed at work. The subject identity of having a mental illness was described as having such negative connotations in society that participants with experience of mental illness would choose to not engage with that subject identity, but they would discuss their physical limitations.

I'd got over cancer and that was quite an achievement . . . but with mental illness people are judgemental . . . it's okay getting back into the workforce when you've had physical ailments . . . but the mental thing is a whole different ball game. (participant with experience of mental illness)

I disclosed my severe arthritis at work . . . but didn't want to disclose my mental illness. That would not go down well. (participant with experience of mental illness)

All participants with experience of mental illness discussed the differences in social perceptions between a visible, physical illness or disability and invisible mental illness. Participants felt that the story of a physical illness was easier for individuals to comprehend whereas the story of mental illness tended to make people, particularly employers and colleagues, uncomfortable.

It's still . . . you're the one that is faulty. (participant with experience of mental illness)

Several participants with experience of mental illness discussed that by admitting to having a mental illness, they were admitting to being broken in ways that society did not easily empathise with. Their self concept was of being faulty, a faulty subject identity, but also being the one who was somehow responsible for being faulty.

The different social perceptions between physical and mental limitations impacted the disclosure decisions of participants with experience of mental illness. Participants generally chose to not disclose their experience of mental illness; this meant that they hid their invisible subject identity and had to work harder to be seen as 'normal' and not be discovered as 'non – normal' subject identity.

I've never really disclosed my mental illness. I could talk about my addictions . . . because that was more socially acceptable. (participant working in mental health)

Addictions were discussed as something easier to talk about than mental illness by one participant with experience of mental illness. This participant felt that people had a better understanding of addiction, possibly because it seemed more tangible like a physical ailment.

Because it's your brain, because it affects your behaviour and your thinking. How do you describe how that's not, fundamentally who you are? Whereas people seem to separate their body from who they are. (participant working in mental health)

Another participant working in mental health, with experience of mental illness, observed that society was better able to separate physical ailments of a body from an individual's character. Whereas a mental illness is seen to be inherently part of someone's character and self, as it is in their brain and impacts their behaviours.

Participants working in human resources and employment settings also articulated the difference in managers' treatment and understanding of individuals with a physical ailment versus a mental illness.

When we're talking about a broken arm, you know, people know the healing process of a broken arm . . . but for mental health? It's quite different to a physical condition. (participant working in employment)

It's so much easier to say, oh that person's broken their arm . . . you know what to do . . . but people struggling to cope, say from anxiety, managers are less skilled in how to deal with that appropriately. (participant working in employment settings)

These participants noted that managers were better able to understand the process of healing in relation to a physical ailment whereas there was not the same understanding of mental illness or distress. The struggle around understanding and responding appropriately to mental illness had impacted most of the participants with experience of mental illness in the workplace. This confusion around mental illness and the negative subject identity of mental illness had also impacted other personal relationships of some participants.

When I was in hospital, my friends didn't come to see me. I can understand that people don't want to deal with it, but even just a text? (participant with experience of mental illness)

One participant reflected on being in the hospital and not being contacted by any of their friends. The participant stated that they did not expect their friends to visit, as they knew that visiting someone with a mental illness was difficult for people, but they thought they might at

least text. However, this expectation described by this participant would not be the expected outcome or understanding in relation to a physical ailment or illness, where visiting a friend in hospital would be seen as normal.

6.6.1: Disclosure and Discrimination Discourse

In response to discrimination discourse and the lack of accommodation embedded within society and in particular work settings, disclosure of mental illness was often avoided by participants with experience of mental illness. The process and experience of disclosure was discussed by all participants. Participants with experience of mental illness had strong views and experiences related to disclosure both in their personal and professional lives. Generally participants with experience of mental illness had chosen to not disclose their mental illness in their workplace. Only one participant with mental illness, who was not working in mental health, had chosen to disclose their mental illness at work. The two participants working in mental health who had experience of mental illness had disclosed their mental illness to their workplace but only did so within their roles in mental health services and not prior to that.

In my company if I was known to be mentally unwell, the job wouldn't be open to me. (participant with experience of mental illness)

Participants had chosen to not disclose that they had a mental illness in most settings, and therefore their invisible subject identity could remain hidden. By not disclosing, participants with experience of mental illness were better able to pass as 'normal', and this often ensured that they were able to obtain employment or sustain employment and not experience discrimination.

A lot of job applications have: are you taking any medication? And lots of people won't write down that they are on antidepressants. (participant working in mental health)

A participant working in mental health observed that many people would not disclose their mental illness on job application forms for fears of being discriminated against. The response to embedded discrimination discourse for individuals with mental illness appeared to be to remain hidden, especially in the workplace where additional neoliberal discourse and pressures of competition, productivity, and efficiency could be unaccommodating to individuals with mental illness.

I think if I told them, people would be watching everything that I do. (participant with experience of mental illness)

Participants with experience of mental illness were concerned about being treated differently at work, of their illness defining them at work, and of having to manage a negative subject identity, and they were fearful of judgement. This fear of discrimination discourse and risk discourse of mental illness motivated a lack of disclosure by participants.

Our illness gets thrown back at us . . . ‘are you taking your meds? You’re being shitty today.’ (participant with experience of mental illness)

I did say to my manager that you know, I do experience depression. Now I can still remember the look on his face and what it was like . . . and that’s the first and last time I shared anything about it. (participant with experience of mental illness)

Participants with experience of mental illness recalled often having received negative reactions to sharing their mental illness, sometimes from previous work environments, sometimes from family and friends, and these experiences fed into their fears around disclosure.

I’ve kept that to myself. On the application form I divulged my physical problems . . . but I felt that there’s still a lot of prejudice and stigma, and sometimes you’re better to just bluff it, and that’s what I did. (participant with experience of mental illness)

Participants with experience of mental illness generally felt that there was still a lot of discrimination around mental illness, particularly in the workplace, and they did not want to risk their employment opportunities or current work situations by disclosing.

Participants working in supported employment also had strong views around disclosure although they admitted that their views were changing.

Whether or not a client discloses is very much on an individual basis, generally we say, don’t. (participant working in supported employment)

Based on the statements made by participants with experience of mental illness, and the participants working in supported employment, it appeared that resoundingly, despite mental health campaigns, mental illness still appeared to be synonymous with silence; participants kept quiet in order to hide their ‘non-normal’ subject identity and to thereby avoid discrimination. Participants working in supported employment generally suggested that their

clients should not disclose their illness or disability, although they noted that it was ultimately an individual's decision.

We'll support that person whether they disclose or not . . . if they don't need to disclose it, you know, there's no need to tell people because you open up that avenue for discrimination. (participant working in supported employment)

One participant working in supported employment noted that by disclosing, clients were making their working lives harder for themselves as this opened up the possibility of being discriminated against.

Our clients just won't compete if you put them against others . . . they just won't compete. (participant working in supported employment)

Participants working in supported employment also noted that their clients already had difficulty competing in the job market, through periods of unemployment, less work experience, or a lesser education, and that disclosing frequently made them even less likely to be employed.

Sometimes employers had asked the participants working in supported employment what a client's particular disability was, or why they needed a service to support them into employment, and this was something that participants struggled to know how to answer.

So that question comes up, and you know, I've been asked 'so what's this person's disability?' How do you answer that question? In such a way that you don't burn their chance of being considered for a job by this employer. (participant working in supported employment)

Discrimination discourse surrounding mental illness appears to be so embedded within work structures that it seems reasonable to decide it is not worth discussing one's mental illness for fear that this will lead to missing out on a job opportunity. While individuals may be more successful at obtaining employment without disclosure, however, silence does mean that the individual's mental illness will not be able to be actively accommodated in the workplace which may mean the employment situation is ultimately harder for the individual to maintain.

Only recently had participants working in supported employment considered being more open regarding disclosure.

I think we might even be changing out mind-set on that . . . just happened one day to meet the HR leader . . . and she said ‘oh, put that all down! If we know that about a candidate, we’ll be able to make arrangements.’ They actually, it was as if they were saying, we’d be more open, and it could be a tick in the favour of the person. You know? I’ve not heard that before. (participant working in supported employment)

One participant working in supported employment had recently met someone working in human resources for a large public organisation who had encouraged the participant to be more explicit in discussing disclosure options with clients.

For participants, part of the tensions and concern around disclosure also centered around how to disclose. A participant working in mental health reflected that sometimes when they were particularly unwell, people wanted to explain and share everything, which was overwhelming for a potential or current employer.

We want to talk about why, explain to people . . . but it can be too much information. Your employer doesn’t give a shit about all that, they just want to know why you haven’t been doing your job . . . it’s like fitting an elephant into a golf hole . . . if we are unwell or have had a period of unwellness, we will tell people everything. (participant working in mental health)

Participants with experience of mental illness sometimes wanted a space to explain ‘why’ they were unwell, as also noted by a participant working in mental health, but frequently this explanation was not what other people wished to hear. Finding a way to explain the individual’s story of their mental illness in a palatable way, one which would not scare away employers, seemed to be too large a challenge, and so it was easier to encourage clients to not say anything.

Sometimes you need to discourage them because it’s that horrible situation of too much information. (participant working in supported employment)

The issue of how to disclose was also discussed by participants working in supported employment. Disclosing too much personal information was described by participants in supported employment as something that could lead to employers not wanting to hire a potential employee.

He might have a job offer, and then discloses too much and the employer just goes, this is ‘too much hard work’. (participant working in supported employment)

One participant working in supported employment noted similarly that job opportunities could be retracted after a client had disclosed too much. Employers heard a story from a client and thought, “it’s too hard”.

The extent to which discrimination was expected and observed by participants working in supported employment further showed the lack of rights and accommodation of individuals with mental illness. The discourse of discrimination, whether based on a discourse of risk around mental illness, or a discourse that individuals with mental illness are less productive and an economic liability, appears to be thoroughly embedded within workplaces and economic structures.

6.7: Conclusion

The data showed that discursive frames surrounding work, particularly work-centric discourse make a major impact on the experience of individuals with mental illness. Workplaces, businesses, and the economy are embedded with competition, productivity, and efficiency discourses, all of which can be very unaccommodating and discriminatory to individuals with the subject identity of mental illness. Work-centric discourse dominates our social systems and this makes it difficult for individuals to have a sense of meaning, purpose, and value outside of work, and impacts individuals’ sense of self during periods of unemployment or when they may have to take time off work. Individuals with mental illness can experience the negative subject identity of being unemployed or being an ‘unproductive worker’ alongside the negative subject identity of having a ‘non-normal’ identity, which in combination make feeling like a worthwhile member of society very difficult.

While workplaces have developed some strategies to respond to needs of employees, these are often supported by discourses that also disable and exclude the ‘unideal workers’. Work/life balance strategies, flexible work strategies, and accommodations do offer some way for employers to support employee with disabilities or mental illness, however, many of these strategies rely on the individual to demand support, or engage with the policies offered, whereas the status quo remains ableist and assumes that individuals do not need support or accommodations. These flexible work policies and accommodations also exist alongside the arguable more dominant discourse of productivity, efficiency, and competition embedded within the labour market, the workplace, and neoliberal structures. The dominance of economic imperatives make the practice or strategies informed by the flexible working

discourse difficult to sustain or apply, especially during times of financial tensions or insecurity within a business and within the labour market.

While the discourse of disability was not dominant within the data, this discourse was present in perspectives on accommodations in the workplace, and is also relevant to explore as frequently administratively mental illness and disability are constructed together. Participants thought that physical or visible disabilities or health issues were easier to share. They thought this might be in part due to the process of physical illnesses and disabilities being more socially understood whereas invisible illnesses or disabilities are unseen, and easily misunderstood. Participants were more likely to disclose physical ailments they experienced in the workplace as they believed these would be better understood and there was less discrimination surrounding these kinds of ailments. Disclosure related concerns, including how to acknowledge a ‘non-normal’ identity, how much to disclose, and whether it was necessary were prominent topics of discussions in the interviews. Disclosure or non-disclosure represented significant strategies for individuals with experience of mental illness to either access accommodations at work or avoid discrimination. The complexity of acknowledging and managing a ‘non-normal’ subject identity in a work environment that prioritises out-puts, productivity, competition, and efficiency is difficult, to acknowledge not fitting within the construction of the ‘ideal worker’ can result in unemployment, shame, social stigma, and isolation.

Mental illness, as highlighted in the findings in Chapter Five, is constructed in numerous ways and each discursive frame impacts the response to mental illness as well as the subject identity of mental illness. The way in which mental illness is constructed significantly affects how services respond to mental illness, as well as how workplaces respond to mental illness. As highlighted in the findings within this chapter, to avoid discrimination, which appears to be a currently common problem embedded within workplaces, most participants with experience of mental illness chose to not reveal or disclose their ‘non-normal’ identity at work. The following discussion chapter develops some of these key findings highlighted within Chapter Five and Chapter Six, and expands and develops these ideas, particularly focusing on the individualistic discursive frame of mental illness and the impacts of this on the subject identity of mental illness, as well as on workplace response

CHAPTER SEVEN: DISCUSSION

7.1: Introduction: Individualisation, the Individual Subject, and the Collective Experience of Mental Illness

As highlighted in the first findings chapter, there were numerous discourses surrounding the experience of mental illness that could be seen reflected in the statements of participants and the documents analysed. An underlying factor of the discursive frames that I observed was the individualisation of the experience of mental illness. Individualisation is a core discursive frame within neoliberal discourse, constructing and emphasising the role of the individual, individual responsibility, and de-emphasising the role of a collective, the role of government, and, in this case, the collective experience of people with mental illness. Emphasis within mental illness discourse and within the discourse of work is consistently placed on the individual subject, the individual's responsibility to maintain and manage their well-being, and the individual's responsibility to find and maintain employment.

The collective reality of discrimination discourse embedded within work settings and other social settings was acknowledged by participants and within the documents but simply navigated or accepted rather than actively resisted. This was in part due, I believe, to a lack of rights discourse surrounding the experience of mental illness and due to a lack of acknowledgment of collective and political aspects of experiences of mental illness.

Disability discourse constructs disability as a structural creation, where the social, political, and physical environment create barriers which are disabling to people. Mental illness discourse does not have this same broad narrative, instead mental illness is constructed as an individual experience, rooted in the genetic or chemical composition of people, or resulting from their personal difficulties and traumatic experiences. The lack of a collective discourse surrounding mental illness and the emphasis on the individual has limited the responses to mental illness. The social strategies and strategies of care for mental illness that are currently in place focus on individualised care and individual management of symptoms, rather than examining social and collective strategies to address the experience of mental illness.

Constructing mental illness as an individual experience also has an impact on the subject identity of people with mental illness. As observed in the second findings chapter, disclosure discourse was significant to most participants, with strong feelings and opinions resulting from experiences of disclosure, and diverse strategies of disclosure being considered. However, most participants with an experience of mental illness chose to not disclose their

mental illness in the workplace, wanting to avoid owning the frequently negatively perceived subject identity of having a mental illness. If participants with mental illness had disclosed their mental illness, they would then have to actively illustrate their control and management of their illness in the workplace to show they were not a 'risk' or not an 'unproductive worker'. Frequently the responsibility sat with the individual to manage their symptoms and reassure their employer that they were part of the 'normal' experience of mental illness rather than a 'risk' or a 'non-normal' identity. This focus on the individual with mental illness within the workplace, and on self-care strategies to maintain well-being, was in contrast with the discourse and strategies around accommodations surrounding people with other disabilities.

When an individual with a visible, recognisable disability is employed, it is more likely, due to existing disability discourse, that a conversation around how the employer and work structures, whether social or physical structures, can be adapted or changed to accommodate the needs of the person with a disability. By contrast, due to the individualised, medical discourse of mental illness, this is far less likely to happen. Instead, participants with mental illness felt that by owning their subject identity as someone with a mental illness, they would be opening themselves up to discrimination discourse, bullying, and potentially unemployment and isolation. Participants preferred to not disclose in order to act the part of a 'normal' employee, to be seen as a 'good worker,' rather than engage the discourse of risk and 'non-normal' surrounding mental illness and miss opportunities to participate meaningfully in society and also have financial security.

Disability discourse appears to offer a contrasting view of how the subject identity of individuals with mental illness might be perceived in the workplace and within wider society. Disability discourse, alongside rights discourse, emphasises the collective experience of a group of people, which can provide alternative responses and strategies to support that group of people. In the case of people with experience of mental illness, widening the discourse from an individual experience to a wider narrative and thereby constructing a collective discourse may be a way by which people with mental illness can construct subject identities that are both 'non-normal' identities but also a subject identity that is powerful, with access to the right to not be oppressed and discriminated against, nor silenced. Instead, this collective subject identity of mental illness can be drawn upon to demand to be accommodated, supported, and have collective needs and experiences acknowledged by society, by the state, and the social structures.

This chapter is divided into four sections, firstly, I discuss the individualisation discourse embedded within mental health structures and work settings. Then, the subject identity of mental illness and how participants and documents engaged with the subject identity of mental illness are examined. Next, I discuss the discursive strategies of disclosure which are influenced by the different discursive frames surrounding mental illness and subject identities of mental illness. Finally, I examine collective discourses in the workplace and wider constructions of collective identities, drawing on disability discourse to offer an alternative way of constructing and responding to mental illness.

7.2: Individualistic Discourse: Neoliberal Work and Health Structures

The discourse of individualisation, a significant component of neoliberal discourse, is embedded within the workplace, the economic system, and within mental health services in New Zealand and western societies (Braslow, 2013; O'Brien, 2013). Individualisation within these services and systems influences the social strategies and responses administered. As highlighted in the literature review, the influence of individualistic neoliberal individualistic discourse on social services, the role of government, and the role of the citizen is significant throughout the world and also in New Zealand (Lunt, 2006; O'Brien, 2013), and this discursive frame of individualisation is reflected in statements and discursive constructions present within the findings.

The experiences of unemployment or having a job of lower-status, fewer hours, or precarious employment are seen as individual problems that an individual must overcome by increasing their employability, productivity, and by managing themselves sufficiently (Lunt, 2006; Patrick, 2012). These experiences of precarious employment, or unemployment, and the individualised discourse of employment and unemployment were highlighted by participants and within documents, particularly in their use of work-centric discourse, which emphasised success, social status, and power of an individual related to employment circumstances. Alongside this, in order to achieve success at work, the data suggested an individual needed to demonstrate being a 'hard worker' or 'productive worker.'

Similarly, mental illness discourse frequently constructs mental illness as an individual problem to be managed through self-help tools, compliance to medication, and the containment or control of risk factors (Moon, 2000; Ringer & Holen, 2016; Schneider, 2010). An individualistic orientation is evident in the construction of mental illness within well-

being and mental health discourse, as highlighted in the first findings chapter, Chapter Five. Documents and statements from participants emphasised the role of individuals to do healthy tasks and manage themselves well in order to be healthy. Individualistic discourse is embedded within social services and social structures, and this discourse inherently separates and isolates collective realities that are impacting groups of people. This discourse also negates the need for structural and systemic change as the responsibility, power, and control is constructed to be with the individual.

7.2.1: The Individual Discourse of Work Circumstances and Unemployment

As discussed in Chapter Five, work-centric discourse highlights that work is essential to social status, financial success, inclusion, and social connection. Conversely, the discourse surrounding unemployment constructs the subject identity of an unemployed person as not fulfilling their duty as a citizen, as lazy, and as dependent (Beddoe, 2014; O'Brien, 2013), and emphasises that it is an individual's responsibility and duty to be both employable and employed (Lunt, 2006). As highlighted in the literature in New Zealand (O'Brien, 2013) and other parts of the world particularly in the UK (Patrick, 2012) and Australia (Soldatic & Pini, 2009), the neoliberal discursive shift has resulted in a change in social strategies and responses to unemployment, and approaches to supporting individuals into work. The welfare state has evolved into a workfare state, illustrating the dominance of work-centric discourse and individualistic discourse.

As noted in the findings chapters, participants with mental illness often experienced periods of unemployment due to either their mental illness or the social stigma and discrimination resulting from their mental illness. Participants with mental illness and participants working in supported employment, while acknowledging that discrimination limited work opportunities and in some cases resulted in people with mental illness not being hired, did not, however, construct unemployment as a wider social problem resulting from discriminatory and unaccommodating workplaces and expectations. Unemployment or employment in lower status jobs, not 'real jobs', were constructed by participants as due to individual circumstance, highlighting the internalisation of individualistic discourse, and the lack of collective discourse and response to the issue of discrimination that often results in unemployment.

As the experience of lower status, precarious, part-time work, or lack of work is placed within an individual's responsibility, it is then difficult for individuals with mental illness to politically and collectively address their situation. Participants and documents highlighted the discourse of discrimination embedded within work processes, for example, mental health leave not being constructed as legitimate sick leave. The discourse of individualisation places the blame and responsibility of employment on the shoulders of the unemployed, and does not encourage examining the labour market circumstances, or critiquing the economic or social structures embedded with discrimination discourse that have often resulted in unemployment (Fejes, 2010). Economic structures are embedded with social strategies designed to increase productivity and competitiveness, all of which are not often able to accommodate workers or employees who are perceived as different to the 'ideal worker' (Humpage, 2007; Jammaers et al., 2016).

The subject identity and social construction of the 'ideal worker' impacts the experience of work for individuals with mental illness and disability alike, their 'non-normal' identities result in employers having to make accommodations and allowances, which are often perceived by employers as a risk, an unnecessary cost, and an uncompetitive choice (Lantz & Marston, 2012; Lennan & Wyllie, 2005; Tse, 2004). While the collective experience of discrimination of individuals with mental illness and disability was observed by participants and the authors of documents analysed within this research, it still remains an individual problem to navigate and solve. Similarly, the experience of mental illness is constructed as an individual health issue and problem to be managed and controlled through particular tasks, medications, and following the guidance of subject identities with authority, as also observed in the findings chapters.

7.2.2: The Individual Discourse of Mental Illness

As discussed in the previous section, an individualistic discourse is embedded within economic structures and employment processes and settings. Similarly, the focus on the individual within mental health strategies, mirrors a neoliberal discursive focus on the individual (Braslow, 2013; O'Brien, 2013). It also fits well with what Scott and Wilson (2011, p. 43) described as the "ideal health consumer", who, within a neoliberal individualistic discourse, takes responsibility for their own health and uses their agency and self-determination to make choices that will ensure their health. In the documents analysed,

well-being and mental health discourse constructed a prescriptive pathway to health through completing healthy, self-help tasks that placed the responsibility of well-being and mental health within the control of individuals. Individual responsibility for health implies that individuals have the power to change their experience of their illness, without expecting any structural, systemic, or political change regarding the collective experience of mental illness. Because mental illness continues to be constructed through well-being, health, or medical discourse, the individual continues to carry the burden of their symptoms and then also has to self-manage and control their symptoms, and behave accordingly to fit within normal society and maintain a 'normal' subject identity.

While individuals with mental illness, psychiatric survivors and consumers have been resisting the medical discourse surrounding mental illness for several decades (Braslow, 2013; O'Hagan, 2004), mental illness is still a health issue, and as one participant with experience of mental illness noted, "it's still you, you're the faulty one". The cause of mental illness is located within the individual, largely ignoring the social, cultural, political, or environmental contexts that might be contributing to the experience of mental illness (Esposito & Perez, 2014). Health-based, well-being or medical constructions of mental illness remain dominant, and are reiterated and reinforced as to do so serves both individuals with mental illness and the health structures in society.

Esposito and Perez (2014) have argued that the medical discourse and medicalisation of mental illness sits well within a neoliberal, consumerist discourse, as this discourse leads to the belief that mental illness can be managed through the purchase and consumption of particular medications. Locating the 'problem' of mental illness within the individual further problematises mental illness and places the burden of an individual's symptoms and the social consequences of their illness and symptoms, including discrimination, stigma, unemployment, poverty, and isolation, back on the individual's shoulders to be managed and take responsibility for. This individualising discourse of mental illness and the individually constructed 'problem' of mental illness has meant that society, particularly government structures and social services, does not have to offer collective responses or enact social and political change with regards to the experiences and realities impacting people with mental illness.

The medical and health discourse of mental illness is pervasive although not unchallenged. Although health professionals rely on the maintenance and affirmation of this particular

discourse, they have also in recent years been challenging the psychiatric and medical discourse of mental illness (Ohlsson, 2018). All participants used both medical discourse and contextual discourse to explain mental illness, however, most of the participants with experience of mental illness tended to explain and make sense of their mental illness through their social experience and through particular life events, constructing their experience through a contextual discourse. As noted within research by Schreiber and Hartrick (2002), individuals with mental illness also often find some relief in the medical and psychiatric discourse of mental illness. For individuals with mental illness, the medical understanding of mental illness can relieve the discomfort of not ‘being normal’ and locate the ‘non-normal’ behaviour and experience within a medical, genetic, chemical understanding which means the individual is not ‘not normal’ but rather sick. This way of understanding mental illness also offers solutions or clear strategies to follow: take medication, learn to manage your illness, which strategies provide a pathway back to ‘normality’ or being able to function again in society (Schreiber & Hartrick, 2002). Alongside medical and health-based discourse of mental illness, recovery discourse has also contributed to the individualisation of mental illness.

7.2.3: Recovery Discourse, Mental Health, and Well-Being Discourse

Recovery discourse has contributed to the individualisation of mental illness, although, based on the findings of this research, recovery discourse appears to be less significant to individuals with experience of mental illness, mental health professionals, and mental health organisations than it perhaps used to be. This is also suggested in O’Hagan et al.’s (2012) analysis of recovery in New Zealand. Only two participants with experience of mental illness discussed the concept of recovery, both of these participants worked in mental health. One other participant with experience of mental illness did discuss recovery, but only to wonder: “Have I got something I can ever recover from?”, framing recovery within a medical discourse of recovery rather than the mental illness understanding of recovery. The difference in connection with the concept of recovery between mental health services and participants with experience of mental illness suggests that the discourse of recovery is evolving, and, within service provision, is perhaps being more and more conflated with the concept of recovery associated with medical discourse of recovery.

Recovery is an evolving discourse and, based on the findings of this research, appears to be being replaced by mental health and well-being discourse that has become the more dominant discourse and understanding of mental illness. Well-being discourse is in some ways similar to recovery discourse, as it also offers tasks and constructs the pathway to health through individual self-management. Recovery discourse and well-being discourse are also constructed in opposition to medical discourse as they focus on more wholistic ideas of mental illness rather than simply biological or chemical understandings of mental illness. Well-being discourse also perhaps offers a simpler concept to engage with.

Another similarity between recovery discourse and well-being discourse is the shift in power away from health professionals to individuals with experience of mental illness (Braslow, 2013). Recovery discourse in particular aims to encourage agency and self-determination to mental health consumers rather than mental health professionals (Braslow, 2013; R. Price-Robertson, Manderson, & Duff, 2017). In this way, recovery discourse offers a clear resistance to medical discourse. Recovery discourse and well-being discourse both construct health and well-being as attainable through the self-management of symptoms, self-help, empowerment, and self-determination of individuals with mental illness, thus reclaiming agency from professional medical control (Anthony, 1993; Harper & Speed, 2012; Scott & Wilson, 2011). The responsibility within recovery discourse and well-being discourse shifts from the professionals to the individuals with mental illness, ‘empowering’ those individuals, while simultaneously placing the problem of self-managing mental illness within the capacity of the individual, who is then encouraged to use various health-based and self-help tools and concepts to manage their illness (Slade et al., 2014).

Individualistic discourse is embedded within well-being discourse and recovery discourse and this impacts the subject identity of individuals with mental illness. The emphasis within these discourses on self-responsibility and self-management add to the pressure on individuals managing the subject identity of mental illness to present as ‘normal’. In response to individualistic discourse and discrimination discourse, participants with experience of mental illness tended to choose to not engage with the subject identity of mental illness, particularly in their workplaces, by not disclosing. Disengaging and not disclosing mental illness relieves an individual of the responsibility of visibly managing their illness, through self-help activities, in order to reassure employers and colleagues that their experience of mental illness is not ‘non-normal’ and it is under control and therefore is not associated with risk.

7.3: Silencing or Disclosing the Subject Identity of Mental Illness

Work circumstance and the experience of mental illness being seen as individual problems, framed within the individualistic discourse, can have a significant impact on the subject identity of individuals with mental illness. Individuals with mental illness have to navigate various, often negative discourses related to mental illness, and in the process manage their subject identity. Mental illness is an object constructed in opposition to what is seen as the ‘normal’ or accepted models of behaviour and ideas in society (Gomory et al., 2013). Therefore mental illness as a subject identity is constructed as a ‘non-normal’ identity.

Individuals may either choose to embrace this ‘non-normal’ discourse of mental illness, resist, or adapt it, and in doing so they impact the way in which it influences their sense of self, their individual identity. Participants with experience of mental illness tended to respond to the ‘non-normal’ discourse of mental illness through a strategy of silence and non-disclosure, particularly within their work settings but also in other social settings. By contrast, one participant not working in mental health and both participants working in mental health with experience of mental illness asserted their experiences and subject identity of having a mental illness in the workplace. These findings and findings of other researchers suggest that the strategies that individuals employ to engage with the subject identity of mental illness, whether a strategy of silence or a strategy of disclosure, often depend on their own self-concept, or identity, and how they choose to manage and understand the stigma attached to mental illness (Anspach, 1979; Ragins, 2008; Thoits, 2011).

7.3.1: Individual Silence: Pass as ‘Normal’ or Resist the Label of Mental Illness

In my research, most of the participants with experience of mental illness adopted a strategy of silence. In order to avoid discrimination and being treated differently, they chose not to disclose their mental illness at work, thereby not revealing their subject identity as someone with a mental illness. The strategy of silence is available to many individuals with mental illness as they generally have the ability to manage and hide their invisible disability, to pass as having a ‘normal’ subject identity (Dalgin & Gilbride, 2003). Although, for participants with experience of mental illness, remaining silent was often not so much seen as an ‘option’ but rather described as a necessity in order to protect their own safety and their economic security. The need to be perceived as normal was a key motivator for participants with experience of mental illness; this was primarily driven by fear of being discovered, being

treated differently, and potentially losing their jobs. Ragins (2008) and Corrigan and Matthews (2003) highlighted that the strategy of managing and hiding an invisible stigma creates stress for the individuals as they are frequently anxious or fearful that they may be exposed or 'outed'. Corrigan and Matthews (2003) additionally noted that concealing the invisible stigma of mental illness has been shown to cause a preoccupation with maintaining the secret, which often results in stress and anxiety. Nevertheless, the fear of discrimination and being treated differently meant that most of the participants with experience of mental illness in this research chose to hide this aspect of their identity and manage the stress resulting from that, in order to appear normal in work settings.

Remaining silent is a decision not only made out of fear of being seen as 'non-normal' and as a result being stigmatised and discriminated against; not disclosing an invisible identity can also be an act of resistance as observed by Thoits (2016). Thoits' (2016) research illustrated that some individuals with mental illness may choose to deflect their label of 'having a mental illness' as a way of resisting the stigma attached to mental illness. Thoits (2016) observed that this acted as a buffer against potentially negative self-esteem and other negative impacts on well-being attached to stigma. Individuals who resist the label of mental illness and therefore remain silent about their experience, often do not see having a mental illness as a large part of their self-concept or as part of their self-concept at all (Thoits, 2016). Ragins (2008) noted that the motivation to disclose and voice the experience of mental illness is diminished when it is not seen as a core part of an individual's identity.

While this strategy of silence as resistance is adopted by some individuals, as noted by Ragins (2008) and Thoits (2011), it was not observed to be used by participants in my research. This could be because the selection criteria for this research meant I interviewed individuals who did identify as having a mental illness. It could also be because many of the participants had a history of managing their mental illness whereas Thoits (2016) observed that individuals who were in their first episode of mental illness or recent personal experience of mental illness were more likely to resist the label of mental illness as part of themselves. Individuals within Thoits's (2011) study who had no recent experience of mental illness were more inclined to construct their current experience as something less 'serious' such as a nervous breakdown, a temporary experience.

By contrast to Thoits's (2011) perspective on this deflection and disengagement from having a mental illness and of remaining silent, Corrigan and Matthews (2003) conceptualised five

stages of identity development, drawn from sexual minorities studies and extrapolated to individuals with mental illness. An individual ‘resisting’ their label of mental illness could be seen to be within the first stage of the identity integration model, labelled ‘identity confusion’ by Corrigan and Matthews (2003). Over time, individuals may engage differently with the label or construction of mental illness and how it relates to their sense of self and identity.

The five stages discussed by Corrigan and Matthews (2003), move from identity confusion, to identity comparison, to identity acceptance, to identity immersion, to, finally, the fifth stage of identity synthesis. While this stage model is simplistic and does not acknowledge the multitude of subject identities an individual can engage with, and was developed in relation to the integration of sexual minority identities, Corrigan and Matthews (2003) argued that it could be applied to individuals with mental illness. However, this model of identity integration presumes that full disclosure and being acceptably ‘out’ is the primary goal for individuals with stigmatised subject identities. Instead, as already noted, some individuals may choose to resist the subject identity of mental illness as they do not believe their experience, behaviour, and way of thinking is ‘non-normal’ and to be associated with the discourse of mental illness. More notably within the participants’ statements, silence appeared to be the necessary response to the current risks of disclosure and the embedded discrimination discourse within society, particularly work settings.

7.3.2: Silencing the Experience of Mental Illness

The silence surrounding mental illness is pervasive, as noted by participants with experience of mental illness, as well as participants working in supported employment. This silence was a choice made by participants in this research out of resistance, or fear, or a feeling of necessity. Only one participant, not working in mental health settings, had chosen to assert their subject identity as an individual with mental illness, thus not resorting to portraying a ‘normal’ subject identity in order to avoid the discrimination discourse surrounding the experience of mental illness.

As noted in the findings, particularly surrounding mental health and well-being discourse in the media, the construction of mental illness tends to focus on ‘normalising’ mental illness but only a narrow experience of mental illness. Whereas in the media documents that were analysed, individuals who were experiencing mental illness, specifically ‘unflattering’ mental illness rather than depression or anxiety, tended to feel silenced and ignored. This narrow

portrayal of the experience of mental illness in the media has been reflected on in studies in New Zealand (Nairn & Coverdale, 2005) and in Europe (Ohlsson, 2018). The palatable description of mental illness, that, as discussed in the findings chapters, is delivered within well-being and mental health discourse, is constructed as a relateable experience aimed to ‘normalise’ mental illness. However, the ‘normalised’ narrative of mental illness, generally focussing on depression and anxiety, portrayed in the media items analysed, did not reflect my participants’ experiences of mental illness, which were messy, uncomfortable, and complex (McAllen, 2017). In New Zealand media, mental health and well-being discourse appears to be simplifying the complexities and realities of mental illness, reducing the discussion to self-help tasks, self-management, and ‘attractive’ and palatable portrayals of mental illness, usually depression and anxiety, although this is changing.

The narrow subject identities of mental illness seem to be evolving, from the ‘non-normal’ risk identity, or the ‘normal’ palatable identity, to a broader examination and critique of mental health and mental illness systems. This can be seen in the evolving discourse of mental illness in the media, highlighted by Ohlsson (2018). Ohlsson’s (2018) noted that the dialogue concerning mental illness in the media in Norway is changing and mental health practitioners and individuals with mental illness are increasingly critical of the mental health services, treatments, and roles of the professionals. This includes a questioning of whether mental illness is ‘non-normal’ and requires medical treatment and correction to be ‘normal’ again. In New Zealand discussions of the mental health system and structures are equally critical and often describe these as being ‘in crisis’ in the media and in reports such as the recent *People’s Mental Health Report* (Elliot, 2017). However, while the mental health systems and services are being critiqued, there is still a persistent silencing of people with mental illness and the experience of mental illness. Even individuals working in mental health settings who experience mental illness are uncomfortable and fearful of discussing their experience, and tend not to in order to avoid discrimination and also to avoid having to manage the subject identity of having a mental illness (Moll et al., 2013). As the portrayal of the experience of mental illness in the media is still narrow, and discrimination is likely, individuals with mental illness have to choose how to engage with the subject identity and prominent discourses of mental illness, and this is often achieved through different strategies of disclosure and engagement with the subject identity of mental illness.

7.3.3: Strategies of Disclosure: Normalising Mental Illness

Disclosure of the experience of mental illness is a strategy that some individuals with mental illness may choose to adopt in work settings and other life settings. The process of disclosure and asserting the subject identity of mental illness is broad and varied, with different variations on how much individuals may choose to disclose and also who individuals choose to disclose to. Ragins (2008) and Irvine (2011) noted that the decision to disclose, and the process and mechanics of disclosure, particularly for individuals with invisible identities such as mental illness, is difficult to navigate.

Participants working in supported employment settings emphasised the difficulty of disclosure, particularly in supporting their clients to obtain work. Often disclosure would result in their clients not being chosen for position, as the assumption by the potential employer was that individuals with a disability or mental illness would not be ‘good workers’ or would somehow be a liability. The participants working in supported employment felt that it was often better to discourage disclosure by their clients in order to obtain employment and also to avoid the instance of disclosing too much and thus scaring potential employers. However, individuals with mental illness may still choose to disclose their mental illness and experience of mental illness for a number of reasons, for practical reasons, personal reasons, and sometimes for political reasons.

Creed (2003) highlighted that asserting your voice is part of the process of self-authorship, writing an identity, and is also part of an individual’s agency. The one participant with experience of mental illness, not working in mental health, who had openly disclosed their mental illness to their workplace constructed their disclosure as a way of accepting themselves and also being in a better position to help others. Within the experience of voicing disclosure, individuals shape their identity and their engagement with society.

Individuals with mental illness may choose to disclose their mental illness, partially with the understanding that having a mental illness is a ‘normal’ experience. This appears to be how mental illness is often discussed today, increasingly the experience of mental illness is normalised, and the differences are downplayed. Anspach (1979) discussed this approach to managing the identity of mental illness, noting that individuals who wish to normalise their identity often state that they are essentially ‘the same as everyone else’. The normalised experience of mental illness, meaning that mental illness is accepted as a ‘normal illness’, is reassuring to an individual, however, it can create some dissonance between their self-

concept and their social reality as despite the individual seeing their illness as a ‘normal’ experience, society may continue to observe their difference and non-normal aspects through discrimination (Anspach, 1979).

Individuals voicing a normalising disclosure of mental illness may also attempt to portray a ‘hyper-normal’ self, over-compensating for the negative assumptions or stereotypes that society has regarding mental illness. In this way, individuals with mental illness seek to maintain a palatable and ‘normal’ subject identity in society, and may voice their experience in ways that allow them to conform and intergrate with the ‘normals’ around them. This can be seen in how participants with experience of mental illness maintained their subject identity as ‘good workers’ or ‘hard workers’ despite at times needing to take time off work and having periods of unemployment.

The disclosure and voicing of invisible identities will, as Ragins (2008) highlighted, benefit individuals by removing the stress of needing to manage a secret and invisible identity, and contribute to a sense of authenticity in being able to be themselves openly. However, a normalising disclosure that downplays difference may mean that individuals do not seek support or accommodation for their different needs, as they wish to sustain a perception of not needing ‘special treatment’. Normalising mental illness is by no means a negative way of adapting the discourse of mental illness, and public health campaigns often aim to normalise the experience of the mental illness in order to reduce stigma, however, this normalising approach to mental illness can mean that the experience of mental illness is shrouded in euphemism and the different realities individuals may experience are negated.

Normalising mental illness, as highlighted in Chapter Five, can result in an attitude that individuals with mental illness do not need special treatment at work. As the participant working in supported employment observed, “everyone’s had depression at some point”, therefore does it really require accommodations and extra support around it? A normalising discourse and disclosure of mental illness can fail to highlight the different needs that people with mental illness may have and the discrimination that individuals with mental illness experience. This maintenance of a ‘normal’ subject identity does not allow structures and systems that are oppressive and discriminatory to be challenged, nor does it suggest that these structures and systems need to accommodate the different needs of people with mental illness. A normalising discourse of mental illness also does not acknowledge some of the

commonalities, collective experiences, and collective differences of people with experience of mental illness.

7.4: Collective Discourse and Subject Identities of Mental Illness

Participants saw stigma and discrimination as a common, collective experience and aspect of the subject identity of mental illness. In this common experience, people can engage with a collective identity, voicing the experience of mental illness in either a normalising or challenging disclosure. Within a normalising disclosure, people are seeking to be seen as part of the collective ‘norm’, a member of society that disputes the presence of anything different within their identity that may keep them apart from society. In this way, individuals can construct their collective identity as a ‘normal’, participating member of society that is no different from anyone else, and therefore they need not be discriminated against or experience stigma. Within the challenging disclosure, and through highlighting a non-normal subject identity of mental illness, people are seeking to be part of the collective of those who are similarly different.

A challenging disclosure strategy is a disclosure that highlights the ‘non-normal’ subject identity of mental illness. In their comparison between the challenging disclosure of ‘non-normal’ sexual identities and mental illness, Corrigan and Matthews (2003) found that disclosure could be a way of speaking out, a way of challenging or resisting the dominant conceptions of ‘normal’, and a means of gaining social power as a collective. Anspach (1979) argued that a challenging disclosure, or the voicing of an understanding of mental illness in this way, was more beneficial to the individual as it allowed individuals to embrace their differences and take an activist stance, speaking to power and demanding that the structures that limit, exclude, and discriminate against individuals with mental illness change. Based on the findings of this research, this discursive frame of mental illness that posits a challenging, non-normal identity, appeared to be underdeveloped perhaps due to the prevalence of discrimination discourse, and also perhaps due to the lack of rights discourse in relation to mental illness. The intent to identify as a ‘non-normal’ subject identity that challenges the social understanding of ‘normal’ and challenges structures and processes that demand particular ‘normal’ behaviours and ways of being, is emulated in the disability movement and within disability discourse. Within disability discourse, as highlighted in the findings, disability groups demanded acceptance and accommodations be made so that people with

disabilities can be seen as legitimate members of society and be able to participate in the workforce despite differences. By constructing mental illness as ‘non-normal’ and disclosing mental illness within a challenging disclosure strategy, people can construct their collective, politicised experiences of mental illness, in the same way that individuals with disabilities lay claim to their collective identity.

Individuals with disabilities, using the social model of disability, have constructed their collective, common identity as a group that is disabled and discriminated against by the structures of society, and therefore as a collective, they can come together to campaign and challenge those structures (Oliver, 1996). The individualistic discourse and normalising discourse of mental illness appears to be more visible and accepted, over the collective discourse and non-normal discourse of mental illness. I argue that this results in a lack of collective and social responses to the collective experiences of people mental illness, particularly the pervasive discrimination discussed by participants with mental illness.

7.4.1: Collective Responses to Collective ‘Non-Normal’ Identities

The construction of mental illness within health, well-being, and medical discourse is part of the reason why the experience of mental illness continues to remain individualised, with less focus given to social and collective realities, experiences, and responses. In both findings chapters but particularly the findings related to work discourse, the social consequences of having a mental illness were highlighted over the specific, individual symptoms of mental illness. Participants discussed their struggles with work, their fears, and experiences of discrimination, their engagement with government services, financial difficulties, their concerns with housing, their isolation, and the impact on relationships, both intimate and in work settings. While they did also note their symptoms, particularly feeling low, lacking motivation, or being anxious, the emphasis was on the former, more social consequences and difficulties.

Schreiber and Hartrick (2002) observed in their research that their participants also related their mental illness experience to particular life situations, financial stress, failed relationships, or other difficult life events. Schreiber and Hartrick (2002) and Ewart et al. (2017) also observed that their participants related their mental illness experience to particular life situations, financial stress, failed relationships, or other difficult life events. In Ewart et al.’s (2017) study, participants identified a number of factors that contributed to their

experience of mental illness including: their limited economic resources, a lack of reliable transport and infrastructure around them, lack of help from benefit services, and the discrimination they experienced from different social institutions and people in society. Individuals with mental illness could benefit from a collective discourse such as disability discourse because while mental illness is still constructed as an individualised, medical, health experience, something internal to be managed, disability is primarily constructed within a broader, social, and environmental understanding

The disability movement shifted perspectives on disability from a medical discourse to disability discourse, which politicised the experience of individuals with disability, who demanded changes to the social and environmental structures so they did not continue to disable individuals (Oliver, 1996; Shakespeare, 2006). The collective experience of poor employment, unemployment, financial insecurity, discrimination, and social oppression is common for individuals with mental illness and for individuals with disabilities, however, as disability is often visible, it is often easier for society to understand and respond to.

Several participants with experience of mental illness had periods of physical illness or had physical disabilities that they were able to disclose to their employers, asking for accommodations in their workplaces. While asking for accommodations for a physical ailment or disability is by no means easy, it was described as easier by those participants with both experience of mental illness and disability. One participant working in management commented that it was also easier for managers to understand a physical experience because they could see the impact it had on employees and they could understand the process of healing that took place if it was a temporary physical illness. Based on these statements from participants, workplaces, social settings, and social services appear to be better able to empathise and respond to physical ailments or physically visible disabilities. The visibility of a disability enables both an easier collective response to disability as well as a clearer collective identity of disability, despite different individual impairments. Additionally, managers, employers, and other people in positions of power can literally see that the physical, social environment may need to be adapted to support someone with a physical ailment or disability, whereas mental illness in terms of collective response and experience is still predominantly invisible.

7.5: Conclusion:

If mental illness was constructed as a collective experience as opposed to an individual experience, what responses and strategies would be offered? The lack of rights discourse in relation to mental illness, alongside the pervasive acceptance and justification of discrimination embedded within social structures, particularly work structures, suggests that a collective response to mental illness is needed. While mental illness discourse has continued to evolve, shifting from a dominant medical understanding to a more social and contextual understanding, as well as to a recovery discourse and well-being and mental health discourse, it still remains predominantly an individualised experience. While recovery discourse and well-being and mental health discourse have offered a shift in power to the service user, to the individual experiencing mental illness, over the health professional, these discursive frames, in doing so, have placed the responsibility of managing the non-normal identity of mental illness on the individual. This is not necessarily a negative outcome, but alongside a lack of addressing systemically embedded discrimination, and the lack of rights discourse associated with mental illness, this is a heavy identity and responsibility to carry, particularly in the workplace.

Discrimination was an experience that all participants with mental illness had encountered and they were so afraid of encountering it again that they hid their stigmatised subject identity, particularly in the workplace, to avoid it. To combat discrimination discourse, a normalisation discourse of mental illness has emerged, one that suggests that everyone experiences mental distress sometimes. This, while helpful in some ways, has led to a division whereby some mental illnesses are considered 'more normal' than others, and as a result has further isolated the 'non-normal' subject identities of individuals who have messy, unpalatable mental illnesses. Despite health campaigns normalising mental illness, most participants did not want to be associated with the identity of mental illness, especially at work where the demands and need to be seen as a productive, good, normal worker are high. Rather than normalising mental illness, to combat discrimination, and to encourage workplaces to see mental illness as a 'normal' component of life, perhaps it would be more helpful to challenge the construction of 'normal' workplace behaviours and expectations, and the non-accommodating subject identity of a 'good worker'.

CHAPTER EIGHT: CONCLUSION

8.1: Introduction

In this research project, I examined the discourses impacting the experience of individuals with mental illness in New Zealand, particularly in the workplace. The discourse of mental illness and the discourse of work were examined in order to see how these framed and shaped the experiences of individuals with mental illness, and also how mental illness was constructed. There are a number of key findings highlighted in previous chapters and this chapter concludes the thesis by examining the implications of several specific findings. These findings are: the dominance of an individualised construction of the subject identity and experience of mental illness, which then informs a lack of collective understandings and responses to mental illness; and the prevalence of non-disclosure of mental illness as a response to discrimination, highlighting the embedded discrimination discourse and ableism within work and social services. The implications of these two findings, which are in many respects interrelated, will be discussed within this chapter.

In addition to more direct implications of the research findings, areas of further study are also discussed within this chapter. This research was completed within two years which created natural limits and boundaries around the scope of the study. However, there are several areas that could be investigated in more depth in order to better understand the experience of mental illness. Topics for such further research could include exploration of identity construction and the subject identities of individuals with mental illness; examination of the processes and strategies of accommodation in workplaces for disabilities broadly, including mental illness; and also further research on rights discourse as it relates and interacts with people with disabilities and mental illness. These areas of further research are discussed and expanded on within this chapter.

8.2: Implications for Individuals with Mental Illness

This research highlighted how mental illness is frequently constructed as an individualised experience. All participants tended to frame and discuss the experience of mental illness within either an individual narrative or within a contextual discourse, or within individualised medical, mental health, or well-being discourse. The documents analysed, including media items and website materials, tended to construct mental illness in a similar way.

Individualising the experience of mental illness and the subject identity of mental illness has meant that the responses and social strategies regarding mental illness reflect an individualised understanding. This has meant that individuals with mental illness were often encouraged to take medication, manage their symptoms, and engage in self-help activities, in order to lessen their 'non-normal' mental states or behaviours. Structural or systemic responses to the experience of mental illness are not clearly evident nor well developed, since the 'problem' of mental illness is seen to belong to the individual rather than the structures and systems in society. Discrimination and lack of accommodation were not seen as social issues that needed to be responded to in a broader sense but rather as individual problems for an individual to navigate.

This individualised construction of mental illness poses new questions: how would society respond to mental illness if the experience of mental illness was constructed as a collective experience? How would the subject identity of mental illness be constructed if it is framed within a collective understanding? Disability discourse was discussed in this research as an alternative framing for mental illness. The understanding of disability, as Oliver (1996) noted, where the social and physical environment disables people, shifts the responsibility and analysis from the individual to the collective. This understanding and construction of disability encourages collective responses to the experience of disability, where physical and sensory accommodations need to be made in order for people with disabilities to access and participate in society. Mental illness is not yet approached with this same understanding or social response, despite mental illness being legally considered a disability; it is not constructed nor understood within the same discursive frame as disability. Instead, the experience of mental illness is silenced or hidden, and as mental illness is an invisible disability, it can be hidden behind all appearances of a 'normal' subject identity.

My research findings suggest that a collective understanding and construction of mental illness could be a way of encouraging collective responses to mental illness, and also a way of encouraging people with mental illness to further challenge the constructions of 'normal' and 'non-normal'. Mental illness, like disability, or like different sexual identities, could be an identity constructed as a positive 'non-normal' with pride, rather than shame and fear that maintains silence around the experience of mental illness. Currently the subject identity of mental illness is not generally framed as a positive one and although it is becoming more 'normalised' in health campaigns and in the media, this 'normalisation' can create pressure for individuals to be perceived as 'more normal than normal' as also noted by Anspach

(1979). Consequently, different states or needs are hidden or downplayed in favour of being accepted.

8.3: Implications for Workplaces

The subject identity and construction of mental illness is relevant in all settings, but is particularly important in the workplace. How mental illness is understood, constructed, and carried by an employer and an employee can result in appropriate accommodations, and therefore in financial security and the on-going benefits of work and acceptance. But a lack of understanding can conversely result in the stress of managing an invisible, stigmatised identity, lack of accommodation, and in active or covert discrimination potentially leading to periods of unemployment and insecurity, all of which can further impact an individual's mental illness. The findings suggest that the experience of mental illness has consistently remained silenced and undisclosed in the workplace. Participants with experience of mental illness generally chose to not disclose their mental illness in order to avoid discrimination. Based on the findings of this research, discrimination discourse appears to be embedded within workplaces, where the experience of mental illness is constructed as 'non-normal' and a 'risk'.

Workplaces are in an important position to respond to the experience of mental illness by addressing the various forms of ableism embedded within work structures. Participants working in employment settings were aware of mental illness and had strategies in place to support their employees. However, these strategies still required the individual to take responsibility for their well-being in the workplace and engage with the activities offered. Using this approach, workplaces are not necessarily accommodating people with mental illness but are providing them with workshops, skills, tools, to manage themselves better. While this approach may provide some limited assistance to some people with mental illness, it does not examine ways in which the employer, colleagues, work environment, work values, or job structures may need to change in order to accommodate difference. Workshops and self-help activities are good reminders for everyone in relation to mental health and well-being, however, this is not an integrated approach for addressing ableism in the workplace, and does not challenge systemic ways in which workplaces may discriminate against people with mental illnesses. Collective, systemic responses are needed to address the collective experience of discrimination.

Workplaces and other social settings need to illustrate in their social practices and strategies that they are concerned about the rights of individuals with disabilities, including mental illness, and also demonstrate they are able to accommodate their employees' needs. Too much of the process of accessing accommodations appears to be led by potential or actual employees, who must courageously disclose their 'non-normal' subject identities and then seek supports and accommodations. The processes of seeking and achieving accommodations are driven by the individual who needs to be accommodated, meaning that work places as a whole remain ableist and cater for the constructed 'ideal worker' (Jammaers et al., 2016). What would a workplace look like if it was inherently designed to be accommodating and accepting of different abilities, ways of contributing, and needs of people? As a society we have an awareness of the rights and accommodations that should be made for individuals with physical disabilities, for example, ensuring wheel chair access. However, we do not have the same equivalent guidelines and understanding for invisible disabilities such as mental illness.

8.4: Implications for Services

Similar to workplaces and employment settings, services, particularly supported employment services, and mental health services as highlighted in this research, frequently focus on individual responses to mental illness. The individual client is supported and then the next individual client is supported. As discussed in Chapter Six, participants working in supported employment frequently witnessed employers discriminating against their clients, but they did not see it as their role to address or engage with the broad issue and experience of discrimination. In this, we see the individualisation of mental illness, but also the individualisation of employment and employment outcomes, which are frequently understood and constructed as an individual issue. Given the emphasis, noted in the findings chapters, on individual responses to the experience of mental illness, and the experience of unemployment or precarious employment, one question that emerges is, how can services respond to the collective experience of mental illness and employment issues? And another is, how can services respond, in particular, to the collective experience of discrimination and the lack of rights discourse in relation to mental illness?

Constructing the experience of mental illness and employment outcomes as a social issue rather than an individual problem results in different responses. Seeing mental illness and

employment outcomes as an individual problem results in the individual getting further training, upskilling, re-writing their curriculum vitae, and developing their communication skills. All of which are helpful skills and useful in the workplace, but still often do not result in employment as the employment structures and hiring process may be inherently discriminatory. Individual responses to mental illness and employment outcomes are often necessary and helpful, but equally the structural, systemic, and social discrimination and lack of accommodation of workplaces and other social settings cannot be ignored or discounted.

Services in their responses and provisions offered to individuals with mental illness, need to also examine how their responses are constructing mental illness. As observed in Chapter Six, some supported employment service websites did not engage with the subject identity of having a mental illness at all, but rather focussed broadly on disability or health issues, in this way not acknowledging the employment experiences of individuals with mental illness, and not catering services to their needs. Similarly, services need to be aware of how they construct mental illness, for example, as observed on the Human Rights Commission website, mental illness in relation to rights is constructed cautiously, discriminating against individuals with mental illness is at times “unlawful” (Human Rights Commission, 2017, para. 1). Given this construction of mental illness and rights, it is not surprising that most participants with experience of mental illness did not engage with the discourse of rights. Services also need to be conscious of how their service responses construct the reality and subject identity of mental illness. Consistently offering individual support while not addressing broader, systemic barriers for people with mental illness, reaffirms the discourse that mental illness is an individual problem. How can services expand their work to respond to the collective realities of mental illness? This may not be attainable or appropriate for all services, but it is a necessary consideration if services wish to encourage accommodation, rights, and acceptance in their work and in other social settings, and promote a positive ‘non-normal’ subject identity of mental illness.

8.5: Further Research: Accommodation, Disability Discourse and the Discourse of Rights

As already stated, there are areas that require further research in relation to this topic, including, for example, examining how better accommodations can be made for people with mental illness in the workplace. Firstly, further examination of diverse identity constructions

is needed, this research did not examine gender, cultural identities, or other significant identity constructions that could impact the experience of mental illness and the experience of work. Secondly, further understanding how disability and mental illness relate, particularly as a way of exploring accommodation workplace is needed. Thirdly, discourse of rights needs to be further analysed, in particular how discursive strategies of rights relate to people with mental illness, and how different understandings of rights impacts subject identities. Finally, while this research does highlight some implications for workplaces and services, it did not examine the discourses within policies and legislation. Therefore, it remains unclear exactly how policy and legislation impact the experience of individuals with mental illness and how they may need to be revised.

8.5.1: Further Exploration of Diverse Identity Constructions

As already discussed, within this research I did not examine diverse identity constructions which could be significant both in how mental illness is experienced and how work is experienced. Examining gender would provide further understanding, particularly as often work and expectations of work are gendered (Lewis et al., 2007). Equally, within a New Zealand context, examination of Māori cultural identity as it relates to the experience of mental illness is needed, as well as further exploration of Māori constructions of mental illness, and experiences at work. This is especially important given that the prevalence of mental illness in New Zealand is much higher within the Māori population (Health and Disability Commissioner, 2018a). Alongside this, there are numerous other subject identities or cultural identities that could be explored to further understand the discourses impacting the experience of mental illness. One that I am increasingly curious about is the subject identity of being a parent. Although not noted within the findings of this research, most of the participants with experience of mental illness in this study were parents or caregivers. How this impacts an individual's identity is uncertain but examining the subject identity of a parent, alongside the identity of having a mental illness, places mental illness within a family context, which would be interesting to explore further as generally, mental illness tends to be framed and constructed as an isolated experience (Wyder & Bland, 2014).

8.5.2: Further Understanding of Disability and Mental Illness

The link between discourse of disability and the discourse of mental illness are tenuous, despite the two being administratively and legally conflated. It would be helpful to do more research examining the similarities and collective experiences of people with mental illness and people with disabilities. To further the understanding of disability and mental illness, it would be helpful to interview individuals with diverse disabilities, to see what common experiences are present and how different disabilities are accommodated or not. As stated in the literature review, there has also been limited research into the experience of mental illness as a disability, or the relationship between the experience of mental illness and that of disability. In order for mental illness to be understood as a collective, social experience, I believe this area of research also needs to be explored further.

8.5.3: Further Examination of Rights Discourse

Mental illness is constructed as an individual experience, and because of this, the rights of people with mental illness are not discussed or provided for. None of the participants with experience of mental illness discussed their rights at work, despite stating that they had frequently been discriminated against. The responses to discrimination discourse embedded within the workplace and other social settings was too often to find alternative employment, or hide the stigmatised subject identity of mental illness, rather than to challenge the discrimination. This research, while observing a lack of rights discourse surrounding mental illness, did not examine the construction of rights itself. The discourse and construction of human rights, disability rights, and the rights of people with mental illness, is a broad area of further research, particularly within a New Zealand context. Perhaps the discourse of rights is diminished in multiple areas, including disability due to the increasing dominance of an individualistic discourse? While disability appears to have a greater association with rights discourse than mental illness, perhaps this is also evolving and becoming more individualised, with a rise in focus on impairments. A critique and greater understanding of rights of people with mental illness is needed.

8.5.4: Further Examination of Policy and Legislation

While this research identified discourses broadly embedded within mental health services and supported employment services, I did not analyse the discourses within particular policies or pieces of legislation impacting the experience of mental illness in New Zealand. Analysing policies and legislation is an area that needs further research. Pieces of legislation that would be interesting to examine further would be *The Human Rights Act 1993*, *The Mental Health Act 1993*, *The Employment Relations Act 2000*, as well as welfare policies and legislation. Alongside examining key pieces of New Zealand legislation, it would also be interesting to examine specific workplace policy documents on accommodation and flexible workplace practices. Examining the discourse within legislation and policy documents would provide clearer understanding on how these documents could be impacting the subject identity of mental illness, and the experience of people with mental illness in the workplace.

8.6: Conclusion

This research began with my personal observations of the experience of a close friend, and his difficulty engaging with mental health services, supported employment services, and managing life amidst an insecure economic environment. His economic reality, and lack of stable employment negatively impacted his subject identity, and also negatively impacted his mental state. These observations propelled me into this research project and the results have been confronting and different from what I had anticipated. I did not anticipate that most of the participants with experience of mental illness would choose to not disclose their mental illness. I also did not realise how commonly mental illness would be seen as a ‘risk’ or as a liability in the workplace, and therefore frequently remain undisclosed. Additionally, I was surprised to find a lack of collective discourse surrounding mental illness, and a lack of collective subject identity.

Mental illness currently relies on individual treatments and well-being related tasks for individuals to manage their experience of mental illness. If mental illness was framed within a collective discourse, raising awareness of common social experiences, what responses would be offered? I have argued that the responses to a collective, social understanding of mental illness would be more likely to result in improved accommodations to the needs of people with mental illness, whether in the workplace or in other social settings. Mental illness needs to be examined broadly, as a collective reality, so society can create collective, social

responses to mental illness and to the economic realities experienced by people with mental illness. This research project reveals the complexity of the experience of managing a mental illness, having the subject identity of mental illness, and trying to participate in society in meaningful ways, while maintaining economic security. It is a starting point, but further research is needed, particularly in further understanding how workplaces and services respond and accommodate different disabilities and the construction and experience of rights of people with disabilities, including mental illness.

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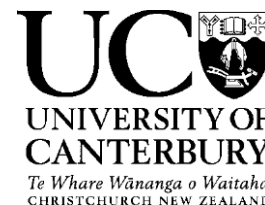
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APPENDIX A: INFORMATION SHEET



Department: Human Services and Social Work
 Email: cassie.welch@pg.canterbury.ac.nz
 20th September 2017

Exploring the Attitudes and Language Surrounding Mental Illness and Employment Information Sheet

I am a current student at the University of Canterbury in the process of completing my Master's thesis. I am exploring how employment and mental illness is currently understood in New Zealand. How social perceptions and understandings of mental illness and social perceptions and understandings of employment and unemployment can impact the experience of work and the work outcomes of individuals diagnosed with a mental illness.

This research will gather perspectives, attitudes, and understandings surrounding mental illness and employment from a diverse range of people including: service providers, employers, advocates, and individuals with personal experience of mental illness. It is expected that this research will add to the knowledge around the economic and social complexities of mental illness, and that it will contribute to practitioners and policy makers.

If you would like to take part in this study, you would be agreeing to take part in an interview that will last approximately 60 minutes. This interview will be recorded so that I accurately type up our conversation.

Once I have typed up our interview, I will ask you to reread it and make sure that it accurately reflects your views. You will be able to add any comments or edits at this point to clarify what you shared in your interview.

Your participation in this research is voluntary and you can withdraw from it at any point without any repercussions. If you no longer wish to be part of the research, I will remove and destroy the data relating to you and your interview within the research project. However, once analysis of raw data starts, it will become increasingly difficult to remove the influence of your data on the results.

The results of the project will be written up in my Master's thesis which will be available at the UC Library, and potentially in other publications. However, no personal information relating to your identity or information relating to your organization will be revealed. If you are quoted in the research document, a pseudonym will be used to protect your identity. The research process will ensure your anonymity and confidentiality. Only my supervisors and I will have access to your data and personal information. All your information and the information that relates to your organization, including the audio recording of our interview will be kept in a password protected folder and any physical copies will be kept in a locked filing cabinet. Five years after this research project is complete, all data will be destroyed.

Please indicate to the researcher on the consent form if you would like to receive a copy of the summary of results of the project.

The project is being carried out as part of a Master's thesis by Cassie Welch under the supervision of Dr. Maria Perez-Y-Perez and Professor Kate van Heugten, they can be contacted at maria-victoria.perez-y-perez@canterbury.ac.nz and kate.vanheugten@canterbury.ac.nz. Feel free to contact them if you have any concerns about this research project.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to participate in the study, please complete the consent form and return it to me via email to cassie.welch@pg.canterbury.ac.nz

Kind Regards,

Cassie Welch

APPENDIX B: CONSENT FORM



Department: Human Services
Email: cassie.welch@pg.canterbury.ac.nz

Exploring Attitudes and Language Surrounding Mental Illness and Employment

Consent Form

Include a statement regarding each of the following:

- ☐ I have been given a full explanation of this project and have had the opportunity to ask questions.
- ☐ I understand what is required of me if I agree to take part in the research.
- ☐ I understand that participation is voluntary and I may withdraw at any time without repercussions. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.
- ☐ I understand that any information or opinions I provide will be kept confidential to the researcher and supervisors and that any published or reported results will not identify the participants. I understand that a thesis is a public document and will be available through the UC Library.
- ☐ I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years
- ☐ I understand the risks associated with taking part and how they will be managed.
- ☐ I understand that the interview in this research will be audio recorded.
- ☐ I understand that I can contact the researcher Cassie Welch, cassie.welch@pg.canterbury.ac.nz or supervisors Dr. Maria Perez-Y-Perez and Professor Kate van Heugten, maria-victoria.perez-y-perez@canterbury.ac.nz and kate.vanheugten@canterbury.ac.nz for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)
- ☐ I would like a summary of the results of the project.
- ☐ By typing my information below, I agree to participate in this research project.

Name: _____ Signed: _____ Date: _____

Email address: _____

Please return this filled out form via email to cassie.welch@pg.canterbury.ac.nz

APPENDIX C: INTERVIEW GUIDELINES

Interview Guide for Participants with Experience of Mental Illness

Tell me a bit about your work history over the last few years – and that can be paid or volunteer work.

Have you ever experienced difficulty at work because of your mental illness?

How did your workplaces support you? Or not?

What do you think is the best support a workplace could give to you or someone in a similar position to you?

Do you enjoy the work you're involved in? / Would you like to be working?

What about working do you appreciate? What worries/ concerns do you have about working?

Have you had times of not being able to work? / Struggling to find work? Could you tell me about those experiences? How did that affect you?

Has there been pressure on you to find work?

Did you have some support to help you find work?

What other support do you think would be useful for people who are unemployed due to their disability / health issues?

If you were to disclose your mental illness to an employer, what would you say? How do you describe your illness?

Interview Guide for Participants Working in Mental Health and Participants Working in Supported Employment

Do you think most of your clients have a desire to work?

Have you found that, in terms of recovery, for most of your clients this includes going back to work?

What have you observed as the outcomes of finding work for your client's mental illness?

Do you think there is sometimes unnecessary pressure for clients to return to work / find work? Why?

What do you see in your role as some of the personal concerns for your clients obtaining and maintaining a job?

What have you found to be some of the key challenges and barriers in the workplace environment for your clients?

How does your organisation work with your client group to be so called 'work ready'?

Do you or would you encourage clients to disclose their mental illness to their employer? Why?

How do you think unemployment impacts client's recovery? / Mental illness?

Whose responsibility is it, do you think, to find work opportunities/ employment for clients?

What might prevent your clients from finding suitable, meaningful work?

What do you think client's experiences of discrimination are in the workplace? What have they shared with you? What happens after that?

How do you / can you support your client when they experience discrimination at work?

What do you think or have you observed with clients who returned to work – did you notice their expectations of work matching the reality of work?

What social/ structural barriers have you observed making it difficult for clients to return to work or gain employment?

How do you think workplaces could better accommodate mental illness?

How do you think social services could better support individuals to return to employment?

Interview Guide for Participants Working in Employment Settings

Do you think work is important for people's well-being and mental health?

How could/ does your org/ business accommodate individual employees with mental illness or disability?

Has your workplace got a policy in place for accommodating mental illness and/or disability?
Could you describe some of the policy guidelines?

What do you imagine are some of the barriers individuals with a mental illness would face when trying to find employment? / maintain employment?

How do you think the issue of disclosure might be supported by a workplace?

How can potential employees / existing staff feel able and safe enough to disclose their mental health issues?

What sort of work environment and workplace culture do you believe could contribute to positive mental health?